Georgia

State Board

of

Workers' Compensation

PROCEDURE MANUAL

This Procedure Manual is to be used as a reference tool in conjunction with and as an adjunct to Title 34, Chapter 9 of the Official Code of Georgia Annotated and the Rules and Regulations of the State Board of Workers' Compensation. The Procedure Manual is updated annually to reflect any changes in the workers' compensation law or rules.

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INSURER/SELF-INSURER REFERENCE SECTION

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Chapter 1

INITIAL PROCESSING OF A CLAIM

Hereafter in this text, "the Board" or "Board" refers to the Georgia State Board of Workers' Compensation. Anyone using a Board form must use the most current revision of the form.

A. Form WC-1 Employer's First Report of Injury or Occupational Disease

The employer completes Form WC-1, Section A and the wage statement on the back of the form immediately upon knowledge of an injury. The employer sends the report to the insurer's claims office. The date the insurer receives the report must be clearly stamped on the report. Upon receipt, the insurer checks the report for completeness and accuracy. The insurer must provide all information requested on the form before filing with the Board.

1. The insurer files Form WC-1 with the Board when:

   a. an injured employee loses more than seven calendar days from work. Cases with seven or less days of lost time should be reported on Form WC-26 (Consolidated Yearly Report of Medical Only Cases.)

   b. an injured employee loses wages entitling him or her to temporary partial disability.

   c. an injured employee has permanent disability.

   d. an employee dies. In cases with date of injury prior to July 1, 1995, a copy of Form WC-1 shall be filed with the administrator of the Subsequent Injury Trust Fund (SITF) at the same time.

   e. an insurer controverts the claim in whole or in part.

   f. an injured employee or attorney representing an injured employee files a claim, if not previously filed.

   g. a catastrophic injury is accepted as compensable (file within 48 hours of acceptance.)

   h. a stipulated settlement is filed. Attach a copy of Form WC-1 for each date of accident covered by the settlement.

   i. a change of physician or treatment is requested for a “Medical Only” case (file along with Form WC-200b.)

2. The insurer completes Section B or C and files the original with the Board and sends a copy to the employee within 21 days of the date of injury or the employer's knowledge of disability. Failure of a report to reach the Board within 21 days from employer's knowledge may result in a penalty (see Board Rule 61(b).)

3. Employee social security number and date of injury are required on Form WC-1 to create a file at the Board. The insurer is responsible for submitting a completed report. If a social security number is not available at the time of filing, a note should accompany the first report asking the Board to assign a temporary number.

4. Form WC-1 should show the complete name and address of the insured employer including all names under which the employer does business. The name and claims address of the individual insurer must be provided. If claims are serviced by a third party administrator (TPA) the name and address of the TPA must be shown in the box provided.

Example:

Employer
John Doe d/b/a Doe's Auto Repair
123 Main Street
Hometown, GA 30303-3030

Insurer/Self-Insurer	TPA/Claims Office
Jones Insurance Company	Smith Claims Service P.O. Box 9999 Atlanta, GA 30303-9999

The complete name and address of the self-insured employer must be shown in the employer block, including the name as it appears on the self-insured permit. The name as it appears on the permit and the complete address of the claims office must be provided in the insurer block. If claims are serviced by a TPA, the self-insurer's name and the name and address of the TPA must be shown in the box provided.

Example:

Employer
Local Services Co./Regional Conglomerate, Inc.
345 Market Street
Hometown, GA 30303-4040

Insurer/Self-Insurer	TPA/Claims Office
Regional Conglomerate Inc.	Smith Claims Service P.O. Box 9999 Atlanta, GA 30303-9999

5. Form WC-1 should include the employer's Federal Identification number and the employer's location address if different from the address previously shown in the employer address block.

6. Form WC-1 should include identification of treatment from a Board Certified Workers' Compensation Managed Care Organization (WC/MCO). Check the box which best describes the source of the medical care provided.

7. The insurer must stamp the Form WC-1 "medical only", in large and preferably red letters, if a case which initially involved no payment of indemnity benefits or payment for medical only subsequently requires filing with the Board. Examples of when it would be necessary to file the stamped WC-1 with the Board are:

   a. An employee is injured but loses no time from work initially. There is medical expense. Later the employee loses time as a result of the injury.

   b. An employee is injured but loses no time from work and incurs no medical expenses for treatment of the injury. Later the employee loses time as a result of the injury.

   c. An employee is injured but loses no time from work. There are medical expenses for treatment of the injury. The doctor gives a rating of permanent partial disability as a result of this injury.

   d. An employee is injured but loses no time from work. There are medical expenses for treatment of the injury. Unauthorized medical expenses are controverted.

   e. An employee is injured but loses no time from work. There are medical expenses for treatment of the injury. A request is made for a change in physician.

8. The insurer must use an original form or approved copy of the original form and print or type all information on the form.

9. If there is an insurer's file number, it should be used on all documents.

B. Form WC-1 Section A

Upon receipt of Form WC-1, the insurer must check to see that the employer has completed all questions in Section A. The insurer must complete any unanswered questions on the form.

C. Form WC-1 Section B

Section B of Form WC-1 is used to commence weekly benefits or to suspend weekly benefits when the employee has actually returned to work at the time Form WC-1 is filed with the Board. In all other cases, the insurer should file Form WC-2. The insurer must furnish a copy to the claimant (see Board Rule 61(b)(1).)

1. The insurer must show payment of maximum benefits unless a wage statement or other explanation accompanies the report (see Board Rules 221(c) and 61(b)(6).)

2. Benefits for temporary total disability are payable from the eighth day of disability. The seven day waiting period is computed as follows:

   The date of disability is the first day the employee is unable to work a full day. If, however, the employee is paid in full for the date of injury, the date of disability begins the next day following the date of injury. The day or days considered lost because of disability to work are counted from the first seven days of disability even though the days may not be scheduled workdays. For example, if an employee who is normally not at work on Saturday and Sunday, is injured on Thursday and is unable to work Friday, the following Saturday and Sunday must be counted as two days of the waiting period. Entitlement to benefits for the first seven days of disability, or any part thereof, requires 21 consecutive days of disability. The employer/insurer shall pay compensation for the first seven days of disability on the 21st consecutive day of disability (see Board Rule 220.)

3. The insurer must fill in the date of first payment of income benefits.

   a. The first payment of income benefits is due on the 21st day after the employer has knowledge of the injury or death, on which day all income benefits then due shall be paid. Thereafter, income benefits shall be due and payable in weekly installments.

   b. Weekly payments are considered paid when due when mailed from within the State of Georgia to the address specified by the employee or to the address of record according to the Board. Payments may also be made by electronic transfer of funds by agreement of the parties. Such payment will be considered to be paid when due at the time they are made by electronic funds transfer to an account specified by the employee.

   c. Payments mailed from outside the State of Georgia are considered paid when due when mailed no later than three days prior to the due date to the address specified by the employee or the address of record according to the

Board. Payments may also be made by electronic transfer of funds by agreement of the parties. Such payment will be considered to be paid when due at the time they are made by electronic funds transfer to an account specified by the employee.

d. If income benefits due without an award are not paid when due, a 15% penalty must be paid at the same time. The penalty is in addition to the accrued benefits.

4. The insurer must show the amount of compensation or salary paid and the amount of any late payment penalty paid at the time of the first payment. Also, indicate whether or not the claim was previously medical only.

5. Indicate the type of weekly income benefits paid.
   a. Total/temporary total disability (O.C.G.A. §34-9-261.)

   b. Temporary partial disability (O.C.G.A. §34-9-262.)

   c. Permanent partial disability (include disability rating, part of body, number of weeks, and attach a copy of the medical report establishing the rating (O.C.G.A. §34-9-263.)

   d. Weekly death benefits must be commenced on Form WC-2a (see Chapter 2.)

6. The date of suspension must be shown when it is known that the employee has returned to work.

D. Form WC-1 Section C

Section C of Form WC-1 is used to controvert in whole or in part the right to compensation or other benefits when filing a first report. Furnish a copy to the employee and any other person with a financial interest in the claim.

The insurer must complete Section C to controvert and must state the specific grounds on which the case is controverted.

E. Form WC-6 Wage Statement

1. Requirements for filing with the Board:

The insurer must file this form when the weekly benefit is less than the maximum under O.C.G.A. §34-9-261 or §34-9-262. See Appendix E, Summary of Workers' Compensation Provisions, for applicable maximum weekly benefit.

Forms WC-1, WC-2, WC-2a, or WC-4 must show payment of maximum weekly benefits under O.C.G.A. §34-9-261 or §34-9-262, as applicable, unless Form WC-6 or other explanation accompanies the form or is already on file.

2. Average weekly wage computation:

   a. Computation of wages shall include, in addition to salary or hourly pay or tips, the reasonable value of food, housing, and other benefits furnished by the employer without charge to the employee which constitute a financial benefit to the employee and are capable of monetary calculation (Rule 260(a).)

   b. If the employee has similar concurrent employment, the wages paid by all similar concurrent employers must be included in calculating the average weekly wage. If the concurrent employment is of the same general nature, it is similar. For example, a record clerk and a sales clerk are similar employment.

3. If a party makes a written request of the employer/insurer, then the employer must send the requesting party a copy of the completed Form WC-6 within 30 days.

F. Methods of Computation

1. The employer/insurer must use the 13 weeks immediately preceding the injury. The employee must have worked substantially the whole of the 13 weeks to compute the wage under O.C.G.A. §34-9-260(1).

2. If the employee has not worked substantially the whole of 13 weeks immediately preceding the injury, the employer/insurer must use the wages of a similar employee in the same employment who has worked substantially the whole of 13 weeks preceding the injury. The employer/insurer must indicate on Form WC-6 if wages provided are those of the injured employee or a similar employee (O.C.G.A. §34-9-260(2).)

3. If the 13-week wage statement of the injured employee or a similar employee cannot reasonably and fairly be applied, the employer/insurer must use the full-time weekly wage of the injured employee (O.C.G.A. §34-9-260(3).)

G. Fractional Part of Week

It is assumed that a normal workweek is five days, that the normal workday is eight hours, and that the employee's daily wage is one-fifth of the weekly pay. Fractional parts of a

day shall be credited proportionally in computing the daily wage. For example, the daily wage of a five-and-one-half day worker is the weekly wage divided by 5.5.

H. Form WC-26 Yearly Report of Medical Only Cases

1. Filing requirements with the Board:

The insurer or self-insurer must file Form WC-26 to report payments for injuries not previously reported to the Board during the year on Form WC-1. This report is a consolidation of payments by the insurer or self-insurer, due on or before January the 31st following the end of each calendar year. File annually even if no reportable injuries or payment occurred during the reporting year.

2. Completing Form WC-26:

a. Name of insurer or self-insurer:

Show individual insurer's name, not the name of insurance group or TPA/ servicing agent. Self-insurers and group self-insurers use name as it appears on the self-insurance permit.

b. Year of report:

Use the calendar year in which the medical expenses are paid. File by the 31st day of January following the end of the calendar year. File even if no reportable injuries or payments occurred during the calendar year.

c. Total number of medical only injuries:

Report separately those medical only injuries of employers utilizing a Certified Workers' Compensation Managed Care Organization. Include all new injuries reported during the calendar year. If no new injuries were reported, enter "0".

d. Total amount of medical only paid during calendar year:

Report separately those medical only payments of employers utilizing a Certified Workers' Compensation Managed Care Organization. Total all medical expenses paid on medical-only cases during the previous year. DO NOT INCLUDE MEDICAL PAYMENTS REPORTED ON FORM WC-4, CASE PROGRESS REPORT. If no medical-only payments were made, enter "0".

e. Provide the name, address and telephone number of the person submitting the report.

References: O.C.G.A. §34-9-108
§34-9-221
§34-9-260
§34-9-261
§34-9-262
§34-9-263
Board Rules 15, 61, 200, 220, 221, 260, 262, 263

Chapter 2

DEATH CLAIMS

A. Form WC-1 Employer's First Report of Injury or Occupational Disease
Form WC-2a Notice of Payment or Suspension of Death Benefits

The requirements for completing and filing Form WC-1 in a death case are the same as in a lost time case of over seven (7) days and the employer/insurer must also submit Form WC-2a.

The information on Form WC-1 of particular importance in a death case is: (1) the marital status of the employee; (2) the date of death; and (3) the number of dependents.

The information on Form WC-2a should always show date of birth, not age, and the relationship of all dependents to the deceased employee.

A determination of whether a death is compensable is, in general, the same as a determination of whether an injury or disease is compensable. If the injury or disease which caused death is compensable, then the death is compensable.

An employee who dies or is found in a dying condition at work or in a place where he or she is supposed to be while working is considered to have died from an injury or disease arising out of and in the course of employment until it is proved otherwise.

B. Beneficiaries and Guardians

According to the 1985 Amendments to the Workers' Compensation Act, a surviving spouse is conclusively presumed totally dependent on the deceased employee for support. However, beginning July 1, 2000, the presumption can only be rebutted by evidence showing that the wife and husband were living separately for 90 days immediately prior to the injury which resulted in the death of the deceased employee. Between 1985 and July 1, 2000, the presumption was rebuttable if the surviving spouse was employed for at least 90 days prior to the injury which resulted in the death of the deceased employee. In determining whether the presumption is rebutted in a particular case, reference should be made to the case of Insurance Company of North America v. Russell, 246 Ga. 269(1980). This case set a standard for determining the dependency of a surviving spouse. According to the standard, a surviving spouse who was dependent on the deceased spouse for support in whole or in part or was in need of such support qualifies as a total dependent of the deceased spouse. Since 1985 it can no longer be said that this standard can be used to establish a conclusive presumption of total dependency. Jones v. Winners Corporation, 189 Ga.App.875(1989). The mere fact that no money changed hands between the surviving and deceased spouse does not in and of itself rebut the presumption of dependency. It is possible that evidence which shows both incomes were necessary to

maintain the couple's life-style may be sufficient to support a finding that the presumption of total dependency has not been rebutted. It has been held that where the surviving spouse earned nearly as much as the deceased spouse and had substantial sources of support from other household members, the presumption of total dependency was rebutted. Goode Brother Poultry Company v. Kin, 201 Ga.App.557(1991). Whether the holding is limited to the particular facts of the case or whether that means the presumption is rebutted as a matter of law if the surviving spouse has any earnings at all for three months prior to the deceased spouse's death is not clear from the Kin opinion.

The absence of proof of a ceremonial marriage of one claiming to be a surviving spouse does not automatically reject consideration. However, after January 1, 1997 the state of Georgia will no longer recognize common-law marriage which might impact claims for injuries occurring after that date.[1]

The marriage of a surviving spouse terminates entitlement to income benefits.

Cohabitation in a meretricious relationship also terminates the dependency of a surviving spouse. Cohabitation in a meretricious relationship as defined by law is two persons of the opposite sex living together continuously and openly in a relationship similar to marriage. See O.C.G.A §34-9-13(e). The employer/insurer may terminate dependency benefits on the basis of a meretricious relationship only by order of the Board.

A child conclusively presumed to be dependent is any of the following:

1. A legitimate natural child, under age 18 or enrolled full-time in high school, and unmarried at time of the injury or disease causing death of the employee.

2. An acknowledged illegitimate natural child, under age 18 or enrolled full-time in high school, and unmarried at time of the injury or disease causing death of the employee.

3. A step-child, under age 18 or enrolled full-time in high school, and unmarried at time of the injury or disease causing death of the employee, if the step-child was actually dependent on the deceased employee for support at the time of the injury or disease causing death.

4. A legally adopted child, under age 18 or enrolled full-time in high school, and unmarried, whose adoption had become final at time of the injury or disease causing death of the employee.

5. A posthumous child.

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[1]O.C.G.A. §19-3-1.1 with passage of this law the state of Georgia will not recognize common-law marriages after January 1, 1997.

6. A child described above, but between the ages of 18 and 22 and a full-time student in a postsecondary institution of higher learning.

7. A child described above, but over age 18 and physically or mentally incapable of self-support at time of injury or disease causing death of the employee.

A child married at the time of the injury or disease causing death does not qualify as one conclusively presumed dependent.

Upon reaching age 18 the dependency of a child terminates, unless the child is enrolled full time in high school or the child was physically or mentally incapacitated from earning a livelihood at the time of the injury or disease causing death of the employee. A child's dependency continues until age 22 if the child is and remains enrolled as a full-time student in a recognized educational institution. There is nothing in the statute to terminate benefits to a child who marries after the date of the injury or disease causing death.

In all other cases whether a person is wholly or partially dependent must be shown by facts establishing actual support in existence at the time of the injury or disease, which caused death, and for a period at least three months prior to the accident.

As long as at least one person is wholly dependent under any of the above situations, persons partially dependent are not entitled to benefits. When no person qualifies as wholly dependent, and there is a balance of income benefits available, any person or persons partially dependent are entitled to income benefits. Partial dependents share benefits among themselves according to the relative extent of their dependency.

Parents include natural parents, stepparents, and adoptive parents.

A surviving spouse with a child or children, if any, qualifying as dependents, is entitled to receive benefits for his or her use, if he or she qualifies as a dependent, and for the use of any child or children who qualify as dependents, unless the Board apportions otherwise. Ordinarily, there is no reason for apportionment, except where dependent children reside in different households. Without exception, if there is any apportionment, it is based on equal shares to or for the benefits of persons wholly dependent.

Between July 1, 1996, and June 30, 1999, the only person capable of representing a minor or legally incompetent claimant entitled to workers' compensation benefits shall be a guardian duly appointed and qualified by the probate court of the county of residence of such minor or legally incompetent person. Said guardian shall be required to file with the Board a copy of the guardianship returns filed annually with the probate court and give notice to all parties within 30 days of any change in status.

After July 1, 1999, O.C.G.A. §34-9-226 provides that the Board may appoint guardians for minors or legally incompetent adults under the following limited circumstances:

1. receipt and administration of benefits not to exceed 52 weeks;

2. to compromise and terminate any claims and receive any sum paid in settlement approved by the Board that does not exceed $25,000; and

3. when there is no guardian for minor or incompetent adult, the Board may appoint a temporary guardian ad litem not to exceed 52 weeks to bring or defend an action under the Workers' Compensation Act.

Forms WC-226 (a) and WC-226 (b) may be used by guardianship petitioners.

C. Death Benefits

Benefits arising from a compensable death consist of the following:

1. The reasonable expenses of the employee's last sickness;

2. Burial expenses not to exceed $7,500;

3. Weekly income benefits for dependents are computed on the same basis as for total disability. Benefits are payable to a surviving spouse or a partial dependent until age 65 or 400 weeks, whichever is greater, and to a child until age 18 or age 22 if a full-time student in a recognized educational institution. For injuries occurring prior to July 1, 1995, there is a limit of $1,000 if all dependents are not citizens or residents of the United States or Canada. There is a limit of $125,000 if the only dependent at the end of one year from the date of death is the surviving spouse.

4. For injuries occurring prior to July 1, 1995, if there are no dependents, a payment is made to the Subsequent Injury Trust Fund. For injuries occurring on or after July 1, 1995, if there are no dependents, a payment is made to the State Board of Workers' Compensation, which is then remitted to the general fund of the state treasury.

The reasonable expenses of the employee's last sickness should be paid directly to the providers of these services. The burial expenses, up to the limit of $7,500, should be paid directly to the provider of these services. Payment to a person other than the provider of the above services can create problems, particularly if more than one person helped pay for services. For example, burial services costing more than $7,500 paid by several relatives. In such a situation, the employer/insurer should request instructions from the Board unless the parties agree on a distribution.

The proper claimant for medical or burial expenses is the supplier of the services, the legal representative of the estate, or another who has actually paid for the services. An employer or insurer making payment for the services directly to a surviving spouse, unless the survivor actually paid for the services or is the legal representative of the estate, does so at the risk of being required to make a second payment to the rightful party.

Persons wholly dependent are entitled to equal benefits. For example, in the case of a surviving dependent spouse with two dependent minor children and a former spouse with one dependent minor child; dividing the maximum benefit equally among the four dependents, each is entitled to $106.25. Thus, the surviving spouse with two children would get $318.75 for his or her use and the use of the two children, and the former spouse would get $106.25 for the use of the minor child. When any child reaches age 18 and up to age 22 if not enrolled full-time in a postsecondary institution of higher learning or high school, benefits terminate, and the amount payable to the other dependents would increase.

The weekly benefit for any person partially dependent is determined by the following formula: Weekly contribution for support divided by average weekly wage times benefit payable to a person wholly dependent.

As an example, a deceased employee had an average weekly wage of $600 and contributed $150 weekly to help support her mother. The benefit amount for the mother is determined as follows:

$$\$150 \div \$600 \times \$425 = \$106.25$$

Where there are several claimants for income benefits, and no doubt exists as to the entitlement of one or more, but the determination of others requires more investigation or litigation, payment to a recognized claimant in the least amount that claimant would receive, with explanation that it may be adjusted upward later, is proper. For example, there is a surviving spouse and a minor child who are admittedly due benefits, and a claim on behalf of a child born out of wedlock probably can be resolved only after litigation. In this example the insurer makes payment of two-thirds of the income benefits to the surviving spouse for the use of the spouse and child, with explanation and accompanying forms furnished to the claimant to be filed with the Board. The insurer should place the remaining one-third in an escrow account until resolution of this litigation.

In cases where there are no dependents, the benefit payable to the State Board of Workers' Compensation is one-half of the amount that would have been payable to a person wholly dependent, if one had existed, or $10,000, whichever is lower. If, after payment has been made, it is determined that a dependent or dependents qualified to receive benefits exist, then the insurer or self-insurer shall be entitled to reimbursement by refund for moneys collected in error.

References: O.C.G.A. §34-9-13
§34-9-225
§34-9-226
§34-9-265
§34-9-281
§34-9-358(a)

Board Rules 61(b)(1,3), 226

Chapter 3

SUBSEQUENT CLAIM PROCESSING

A. Suspension of Income Benefits - Forms WC-2 and WC-3

1. Unilateral Suspension by Insurer

The first use of Form WC-2 (Notice of Payment or Suspension of Benefits) is to suspend the weekly benefit payment when a change in disability status occurs after Form WC-1 has been properly filed with the Board. The form is used to notify the employee and the Board of suspension of income benefits. Form WC-2 is the proper form to report any change in income benefits, classification, or rating of disability. Form WC-3 (Notice to Controvert) is intended to deny liability in whole, or in part, after Form WC-1 has been filed with the Board, and serves the same purpose as Section C of Form WC-1.

For suspension of income benefits, the insurer/self-insurer file Form WC-2 with the Board, and where needed a Form WC-3 or other documents as stated below, and furnish a copy to the employee when:

a. The employee returns to work for the same or another employer at a wage equal to or exceeding the average weekly wage at the time of the disabling injury.

b. The employee is released to return to work without limitation. The insurer/self-insurer must attach supporting medical information from the authorized treating physician to the Form WC-2 filed with the Board. The insurer/self-insurer must give the employee ten days advance notice of the suspension of income benefits. Unless there is compelling evidence to the contrary, the date stamped by the Board as its date of receipt is deemed to be the date the employee received notice.

c. The employee is released to return to work with restrictions and the employee refuses to attempt to perform a suitable job when the requirements of Board Rule 240 are met.

d. The employee dies. The insurer/self-insurer must furnish a copy of the Form WC-2 to the representative of the estate of the deceased employee, if known, and attach a copy of the death certificate, if available. If the insurer/self-insurer contend that the death is unrelated to the injury, a Form WC-3 should accompany the Form WC-2.

e. If, within 60 days after the due date of the first payment of income benefits (which is 21 days after the employer's notice or knowledge of a lost time disabling injury or disease), the insurer/self-insurer determine to controvert the payment of income benefits for any reason, a Form WC-3 must be filed with the Form WC-2. The insurer/self-insurer must furnish a copy of the Form WC-3 to all persons having a financial interest. To meet the 60-day deadline the documents must be filed with the Board, as shown by the Board's date stamp, within 60 days after the due date of the first payment of income benefits.

f. If, more than 60 days after the due date of the first payment of income benefits (which is 21 days after the employer's notice of a lost time disabling injury or disease), the insurer/self-insurer determine to controvert on the basis of newly discovered evidence, Forms WC-3 and WC-2 must be filed with the Board. While not stated in Board Rule 221, the law requires that the insurer/self-insurer give the employee 10 days advance notice of the suspension of income benefits. The insurer must furnish a copy of Form WC-3 to all persons having a financial interest.

2. Board Order or Award to Suspend

Unless otherwise specified, a Form WC-2 is not used to suspend benefits that are being suspended pursuant to a Board order or award. When an Administrative Law Judge or the Board issues an order or award suspending benefits, the order or award is mailed to the address of record of all interested parties and provides authority and notice of the suspension. The basis for a Board ordered suspension of income benefits may include any of the following:

a. The refusal of an employee to accept available work suitable to the employee's capacity to work. This most commonly arises when the authorized treating physician limits the employee to light duty work, and the employer undertakes to provide suitable light duty work. Board Rule 240 sets forth the procedures to follow to effectuate the suspension of income benefits.

b. The refusal of an employee to submit to treatment. O.C.G.A. §34-9-200 and 200.1 specify treatment as medical, surgical, hospital care, vocational rehabilitation, or other treatment provided by the law. Board Rules 200(d) and 200.1(h) permit suspension of income benefits only by order of the Board.

c. The refusal of an employee to submit to a medical examination. Board Rule 202(c) permits suspension of income benefits only by order of the Board.

d. A change in the employee's condition for the better.

B. Changing Benefits from Temporary Total to Temporary Partial

When the authorized treating physician has released the employee to return to work with restrictions or limitations as required by O.C.G.A. §34-9-104(a) and the injury is not catastrophic, the insurer/self-insurer must complete Form WC-104. Form WC-104 must be received by the employee or by counsel for the employee within 60 days of the release to return to restricted work by the authorized treating physician. The insurer/self-insurer shall file a copy of the completed Form WC-104 with the Board. If the employee has not returned to work within 52 consecutive weeks or 78 aggregate weeks the insurer/self-insurer are authorized to file a Form WC-2 to change weekly disability benefits from temporary total to temporary partial disability. A copy of the authorized treating physician's report stating the employee's ability to return to work with restrictions or limitations must be attached to the Form WC-2 filed with the Board and Section B.5 on Form WC-2 must specify that the employee's injury is not catastrophic.

For the purposes of calculating temporary partial benefits as contemplated by Code Section 34-9-104(a), benefits shall be paid as follows:

1. When an employee is receiving the maximum benefits for temporary total disability, under Code Section 34-9-261, the employer shall cause to be paid the employee an amount equal to the maximum benefit allowed for temporary partial disability, under Code Section 34-9-262; or

2. When an employee is receiving less than the maximum allowed for temporary total disability, the employer shall continue to pay the employee the same benefits as provided by Code Section 34-9-261 not to exceed the maximum benefit provided for temporary partial disability, under Code Section 34-9-262.

C. Forms WC-2 and WC-3 Information Required

1. Form WC-2

a. Provide complete information as requested. The most common omissions are the employee's social security number, the date of accident, and the telephone number of the claims administrator.

b. Check whether treatment is provided by a Board Certified Workers' Compensation Managed Care Organization (WC/MCO).

c. Show individual insurer/self-insurer's name, as well as servicing agent's name, address, and telephone number.

2. Form WC-2 The Body of the Form

a. Part A of Form WC-2

(1) If income benefits are being paid, show first, middle initial and last name of the person receiving benefits.

(2) Complete weekly income benefit and average weekly wage. If the weekly income benefit is less than the maximum amount of temporary total disability benefits allowed by law, attach a Form WC-6 to Form WC-2, unless previously filed.

(3) Show the "date benefits are payable from" as the date of disability. If the waiting period is not payable, show the date as the eighth day of lost time after disability.

(4) Check the type of disability and provide the permanent partial disability rating if applicable.

(5) Show the date of the first check as the date the payment is mailed or made to the employee or the date salary was paid instead of weekly benefits. Timely payments must be mailed from within the State of Georgia by the due date, which is 21 days after the employer's knowledge or notice of lost time disability. Timely payment made from outside the State of Georgia must be mailed no later than three days prior to the due date.

(6) Show the total amount paid and indicate the percentage and amount of any late payment penalties.

b. Part B of Form WC-2

(1) The date of suspension is the date the event occurs which authorizes suspension, except for the 10-day notice to the employee when it is determined that the employee is able to return to normal duty work, but has not returned to work.

(2) The reason for suspension of weekly disability should be indicated, and will be one of the following:

___ B. Benefits will be suspended on ___/___/_____, because:

__ 1) Employee returned to work on ___/___/_____, without restrictions from the authorized treating physician.

___ 2) Employee returned to work on ___/___/_____, with restrictions from the authorized treating physician, at pre-injury or higher rate of pay.

___ 3) Employee returned to work on ___/___/_____, with restrictions from the authorized treating physician, at reduced pay of $_____ per week, and temporary partial disability benefits are shown in Part A above.

___ 4) Employee was able to return to work on ___/___/_____, without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached. (Board Rule 221.)

___ 5) The employee has had a change in condition pursuant to O.C.G.A. §34-9-104(a)(2) because he or she is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty (60) days of the release. Temporary partial disability benefits are shown in Part A above.

___ 6) This was not a catastrophic injury, and the maximum number of temporary total disability payments has been paid.

___ 7) The entire permanent partial disability benefit has been paid.

___ 8) The maximum number of temporary partial disability payments has been paid.

___ 9) This claim is being controverted within sixty (60) days of the due date of first payment, and a Notice to Controvert, Form WC-3, is being filed with the Board, with a copy sent to the employee.

___10) Other:_____

_____

3. Form WC-3 The Body of the Form

a. State the reasons why liability is being controverted in whole or in part. General statements to the effect that "liability is not being accepted pending investigation" or "the right is reserved to controvert on further grounds" alone are not acceptable. The employee or potential beneficiary is entitled to know precisely why and to what extent the claim is being controverted.

b. List the distribution in the space provided and furnish copies to the employee and any other person with a financial interest in the claim including, but not limited to, the treating physicians and attorneys in the claim.

D. Recurring Total and Temporary Partial Disability

Where liability is accepted to pay weekly income benefits and a Form WC-1 has been filed, Form WC-2 is used to show the commencement and suspension of benefits as the events occur. The events and procedures to effect suspension are covered in Chapter 3, Section A. Form WC-2 is used to commence weekly income benefits for recurring disability when:

1. The employee ceases to work for the same or another employer because of the work-related injury, which constitutes a change in condition and not a new accident. An economic loss of wages due to the work-related injury must occur, and this economic loss ordinarily takes place when there is a gradual deterioration of physical condition resulting from the injury, which may or may not be attributable to working conditions subsequent to the injury.

   A frequent area of litigation (particularly if one employer and two insurers are involved or if two employers and two insurers are involved) is whether the inability to continue working involves reinstatement of benefits as a change in condition, or whether it is a condition to be treated as a new accident. Consequently, general guidelines only are stated herein, primarily to guide the investigator before seeking legal advice. The questions below will produce facts on which to reach a decision:

   a. Is the disability to work due to a gradual deterioration, but not the result of any specific incident at work? If the answer is affirmative, it is likely that a change in condition has occurred.

   b. Is the disability to work due to an aggravation of injury by conditions while working for the same employer, but not because of any specific incident? If the answer is affirmative, it is likely that a change in condition has occurred.

   c. Is the disability to work due to an aggravation of the injury while working for another employer? Did the new job involve changed work duties which bear some relationship to the present disability to work? Was there a specific incident while working on the new job which bears some relationship to the disability to work? An affirmative answer to any of these questions is indicative of a new accident instead of a change in condition.

2. The employee ceases to work for the same or another employer because of medical treatment including, but not limited to, therapy, surgery, hospitalization, or medical examination resulting from the work-related injury.

3. The employee ceases to work for the same or another employer and is unable to find any suitable work because of an impaired condition resulting from the work-related injury.

4. The employee, although working for the same or another employer, is unable to earn as much or more than his or her average weekly wage at the time of the disabling injury, subject to all of the following conditions:

   a. The economic partial loss of earnings results from the work-related injury. This may be due to limitations imposed by the authorized treating physician involving lifting, movement, number of hours, or due to the lack of suitable work;

   b. The economic partial loss of earnings occurs within 350 weeks from the date of injury; and

   c. The economic partial loss of earnings is a temporary situation. This is the most frequently overlooked condition to determine whether an employee is entitled to temporary partial disability benefits based on a partial loss of earnings, or permanent partial disability based on a permanent physical impairment. The partial wage loss is defined in the law as a disability to work partial in character and temporary in quality. Thus, if the partial wage loss is one which is a permanent loss, it does not meet the requisite temporary quality. Whether to treat the loss as temporary or permanent depends upon a careful evaluation of various factors, including:

   (1) Whether the impairment has reached maximum improvement and whether it temporarily or permanently affects earnings ability.

   (2) Whether normal seniority job promotions, vocational rehabilitation training, experience or other variables will cause the employee in the future to increase earnings to the level of the average weekly wage at the time of injury.

E. Permanent Partial Disability

1. Entitlement

Form WC-2 is used to commence income benefits for permanent partial disability or to change classification of income benefits to permanent partial disability

benefits. The conditions which entitle an employee to permanent partial disability income benefits include all of the following:

a. Not entitled to income benefits for total disability to work.

b. Not entitled to income benefits for temporary partial disability to work.

c. A permanent impairment exists attributable to work-related injury involving the loss of, or the loss of use of, a body member or the whole person as listed in the schedule in O.C.G.A. §34-9-263 or entitlement for occupational loss of hearing under O.C.G.A. §34-9-264.

2. Determination of Loss of or Loss of Use of a Body Member

The determination of the extent of the loss is made by the authorized treating physician and stated in terms of disability to the particular member injured or the whole person. The disability is not a disability to work, but is a physical disability, perhaps better understood if thought of in terms of an impairment.

The percentage of loss or status for certain conditions listed in O.C.G.A. §34-9-263 is controlled by law. These are:

a. Impairment ratings. In all cases arising under this chapter, any percentage of disability or bodily loss ratings shall be based upon Guides to the Evaluation of Permanent Impairment, fifth edition, published by the American Medical Association.

b. Loss of more than one major member. Loss of arms, hands, legs, or feet, or any two or more of these members, or the permanent total loss of vision in both eyes shall create a rebuttable presumption of compensable permanent total disability.

References: O.C.G.A. §34-9-1
§34-9-104
§34-9-200
§34-9-200.1
§34-9-220
§34-9-221
§34-9-240
§34-9-260
§34-9-261
§34-9-262

§34-9-263

Board Rules 61(b)(2,3), 104, 200, 200.1, 221(c,d,e,h,i), 220, 221, 240, 263

Chapter 4

THE CASE PROGRESS REPORT
(FORM WC-4)

A. General

The Board uses Form WC-4 for periodic review of a claim. It is the basis for benefit cost collected by the Board. Filing Form WC-4 as required by Board rules enables the Board to close cases promptly and provides accurate and current benefit cost figures.

B. Filing Guidelines

Form WC-4 is required in all cases in which a Form WC-14 (Notice of Claim or Request for Hearing/Mediation) or Form WC-1 is filed with the Board. The employer/insurer should use the following guidelines:

1. Board rules require filing as follows:

    a. Within 180 days of the first date of disability;

    b. Within 30 days from last payment for closure;

    c. Upon request of the Board;

    d. Every 12 months from the date of the last filing of a WC-4 on all open cases;

    e. to reopen a case;

    f. With all settlement documents; and

    g. Within 90 days of receipt of an open case by the new third party administrator.

2. File a reopened Form WC-4 to show additional payments on previously closed cases or when an employee requests a hearing on a previously closed claim.

3. Form WC-4 should always indicate whether it is an initial, supplemental, final or reopened report and it should also indicate whether the employer is enrolled in a Board Certified Workers' Compensation Managed Care Organization (WC/MCO).

4. The top section should show the employee's social security number and date of injury. If a different social security number or date of injury is furnished, send a letter of explanation reflecting the correct social security number or date.

5. Show date of first payment made to employee in Section 1.

6. Show in Section 2 the type and amount of income benefits paid at the time the report is filed.

   a. Temporary total disability income payments under O.C.G.A. §34-9-261.

   b. Temporary partial disability income payments under O.C.G.A. §34-9-262.

   c. Permanent partial disability income payments under O.C.G.A. §34-9-263 and §34-9-264. This includes payment made in a lump sum for permanent partial disability.

   d. Death income benefits under O.C.G.A. §34-9-265. This includes payment made in a lump sum. Payment made to the State Board of Workers' Compensation in death cases where there are no dependents must be shown in this section. Burial expenses must be shown in Section 4(11) Burial Payments.

   e. Lump sum amounts paid in stipulated settlements and advances. Amounts paid for no liability stipulated settlements should also be included in this section.

7. Reimbursement of income benefits made by the Subsequent Injury Trust Fund MUST be included in amounts shown in Section 2, and omitted in amounts shown in Section 4(1).

8. When salary is paid in lieu of income benefits, the period for which payments would have been made and the amount of income benefits that would have been paid must be shown in Section 2(a).

9. Show first disability date in Section 3. This date should remain the same on subsequent Case Progress Reports (Form WC-4) filed with the Board.

10. Section 4 must show all payments as of the date the report is filed less reimbursements made by the Subsequent Injury Trust Fund.

    a. Total Weekly Benefits. The amount shown must be the total of all payments shown in (a) through (e) in Section 2, less reimbursements made by the Subsequent Injury Trust Fund.

b. Physician Benefits. Show all payments made directly to a physician or medical group (not a hospital or hospital clinic).

c. Hospital Benefits. Show all payments made to hospitals; include emergency room, outpatient care, inpatient care, and all other services provided by hospitals.

d. Pharmacy Benefits. Show all payments to pharmacies, including reimbursements for drugs and non-prescription items.

e. Physical Therapy. Show all payments for physical therapy, including education and patient care (not hospital or hospital clinic).

f. Chiropractic. Show all payments to a doctor of chiropractic medicine or chiropractic clinic.

THE COST OF MEDICAL CARE DOES NOT INCLUDE ANY AMOUNTS PAID FOR UTILIZATION OR BILL REVIEW

g. Other (Specify). Show other related expenses which do not belong in another category. These include travel expenses (meals, lodging, mileage, etc.), home health care, nursing home care, home modification, and automobile or van modification.

h. Rehabilitation. Show services of rehabilitation suppliers and training expenses not reported in sections 4(1-7) (supplier fees, tuition, fees, books, supplies, transportation costs, etc.)

i. Late Payment Penalties. Show payment of all 15% and 20% late payment penalties provided for in O.C.G.A. §34-9-221(e) and (f).

j. Assessed Attorney's Fees. Show attorney's fees assessed as a penalty pursuant to O.C.G.A. §34-9-108(b). Do not show normal payment of attorney fees which are part of the employee's benefit or part of a settlement. These must be shown in Section 2 and Section 4(1). Do not show payments made to the attorney for the employer/insurer.

k. Burial. Show burial expenses when paid. Maximum is $7,500.

11. The amount of Subsequent Injury Trust Fund reimbursement (indemnity and medical) should be shown in the remarks section of the Form WC-4.

12. The amount of subrogation recovery pursuant to O.C.G.A. §34-9-11.1 should be shown in the remarks section of the Form WC-4.

13. Sections 5 through 11 should be completed by the insurer, if applicable, at the time the report is filed. Complete Section 5 if the employee has returned to work at the time the Form WC-4 is filed. When filing a final report, provide the closing date in Section 8 and the date of final weekly payment in Section 10.

14. Provide the name and address of the insurer or self-insurer. If the insurer is part of a group that is using preprinted forms for more than one company, the name of the company insuring the loss should be indicated. If the claim is handled by a TPA, provide the name of the insurer and the name and address of the servicing agent.

15. Type or print the insurer's name and address in the space provided. Include the phone number of the person (adjuster) authorized to answer any questions regarding the information contained in the Form WC-4 and place it on top of any accompanying correspondence.

16. File the original form with the Board.

References: O.C.G.A. §34-9-261
§34-9-262
§34-9-263
§34-9-264
§34-9-265

Board Rule 61(b)(5)

Chapter 5

LUMP SUM AND ADVANCE PAYMENTS

A. Definition

O.C.G.A. §34-9-222(a) defines a lump sum payment as "…payment of a lump sum equal to the present value of all future payments of income benefits commuted at 7% per annum."

Pursuant to Board Rule 222(a), the Board will consider an application for either a lump sum payment of all remaining income benefits or an advance of a portion of the remaining income benefits, but it will not consider any application unless benefits have been continued for at least 26 weeks. The employer/insurer may make a lump sum or advance payment without commutation of interest and without an award from the Board.

B. Application Procedure

In lieu of a hearing, the Board will consider applications for advances and lump sum payments in accordance with the following procedure:

1. A request for an advance or lump sum payment must be submitted on Form WC-25, and a copy must be sent to the employer/insurer and any other interested parties. The applicant must complete the affidavit on the back of Form WC-25 as well as the following information:

   a. The minimum living expenses, including rent, groceries, utilities, etc.

   b. A list of long-term debts, including mortgage on home, furniture, automobile, etc., including, for each total due, date the debt was incurred, to whom owed, amount of monthly payment, and purpose of debt.

   c. A list of the total income of the household from all sources.

   d. A list of emergency needs required to prevent extreme hardship or irreparable damage to the welfare of the family and employee or essential to the rehabilitation of the employee.

   e. A showing of need for the lump sum or advance payment and the proposed use of the funds requested.

   f. A list of the total number of children and their ages.

   g. The fee of the attorney for obtaining the lump sum or advance payment.

2. If the request is for an advance, a proposed method of repayment must be included on Form WC-25.

3. A medical report no older than 60 days showing the physical status of the employee including the extent and duration of disability, and current permanent partial disability rating, if any, must be attached to the Form WC-25. Copies of contracts that show long-term debts must be attached or the request will be denied. Documentation for all past due bills must also be attached to the Form WC-25.

4. The Certificate of Service statement on the back of Form WC-25 must be completed with the date the document is mailed or delivered.

5. The parties have 15 days from the date of the Certificate of Service to file objections to the application (the 15 day period begins with the date the Certificate of Service document is mailed or delivered). Objections to an application must be accompanied by documents in support of the objections, may be accompanied by counter-affidavits, and must be served upon the party or the attorney making the application. The Certificate of Service on the back of Form WC-25 must also be completed.

6. If any party elects to cross examine an adverse party, it must notify the Board within 15 days of the date of the Certificate of Service on the Form WC-25 of its intention to submit a deposition. The deposition must be filed with the Board no later than 30 days from the Certificate of Service on Form WC-25, unless the Board upon a showing of just cause grants an extension.

7. If, in the judgment of the Board, there are material and bona fide disputes of fact, the Board may schedule a hearing or assign the case to an Administrative Law Judge for the purpose of receiving evidence.

8. After July 1, 1996 applications for lump sum or advance payments not made on Form WC-25 or not properly filed will be returned as insufficient.

References: O.C.G.A. §34-9-222(a)(b)

Board Rules 61(b)(14), 222

Chapter 6

MEDICAL BENEFITS

A. Authorized Treatment

1. Method of Providing Medical Treatment

The employer may satisfy the requirements for furnishing medical care in one of the following manners:

a. The employer shall maintain a list of at least six non-associated physicians or professional associations or corporations of physicians who are reasonably accessible to employees. This list shall be known as the "Panel of Physicians." At least one of the physicians must practice the specialty of orthopedic surgery. Not more than two physicians on the panel shall be from industrial clinics. One physician on the panel must be a minority. The employee may make one change from one physician to another on the same panel without prior authorization from the Board.

However, the Board may grant exceptions to the required size of the panel where it is demonstrated that more than six physicians or groups of physicians are not reasonably accessible. In the event that the Board has granted an exception to any panel requirements, the exception must be posted in the same location as the panel.

b. The employer may maintain a list of at least 10 physicians or professional associations reasonably accessible to the employees and providing the same types of healthcare services specified in Board Rule 201(a)(1) and the following healthcare services: general surgeons and chiropractors. This list shall be known as the "Conformed Panel of Physicians."

c. An employer or the workers' compensation insurer of an employer may contract with a managed care organization certified by the Board. Medical services provided in this manner shall be known as "Managed Care Organization Procedures." Employees shall be given notice of the managed care organization's network of eligible medical service providers and information regarding the contract and manner of receiving medical services, including a toll free 24-hour telephone number that informs employees of available services.

d. An employee may obtain the services of any physician from the panel and may thereafter elect to change to another physician on the panel without

prior authorization from the Board. The physician so selected will become the primary treating physician in control of the employee's medical care.

If the panel of physicians is not posted or properly utilized, the employee may see the physician of his or her choice at the expense of the insurer/self-insurer. (See Section A-2 below).

The term, "physician," shall include any person licensed to practice a healing art and any remedial treatment and care in the State of Georgia.

"Minority" shall be defined as a group which has been subjected to prejudice based on race, color, sex, handicap or national origin including, but not limited to, Black Americans, Hispanic Americans, Native Americans, or Asian Americans.

2. Other Authorized Physicians

A referral by an authorized treating physician for the specific purpose of consultation, evaluation, testing, or diagnosis in connection with treatment prescribed by the authorized treating physician does not constitute a change of physician or treatment and does not require an order from the Board. However, a referral physician shall not be permitted to arrange for additional referrals.

A referral by the authorized treating physician for the purpose of providing the employee with a specific treatment or a special medical service which is related to the employee's compensable condition does not constitute a change of physician or treatment and does not require an order from the Board.

If an employer, after becoming aware of an injury, fails to provide adequate treatment for the injury, the employee may seek treatment from the physician of his or her choice at the insurer/self-insurer's expense. A failure on the part of the employer to render appropriate assistance to the employee or explain the employee's rights in making a selection or arranging for treatment from a posted panel, conformed panel, or managed care organization, may constitute failure to furnish adequate treatment. Notwithstanding any selection made pursuant to his or her panel rights, an employee, after a compensable injury and within 120 days of receipt of any income benefits, shall have the right to one examination at a reasonable time and place, within this state or within 50 miles of the employee's residence, by a duly qualified physician or surgeon designated by the employee and to be paid for by the employer/insurer. Such examination shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury unless the costs of such diagnostic procedures which are in excess of $250 are paid for by a party other than the insurer/self-insurer.

If an emergency situation arises in which there is not time to comply with selection requirements, the injured employee is authorized to seek treatment from a physician of his or her choice; this authorization lasts for the duration of the emergency. An emergency may be defined as "an unforeseen occurrence or combination of circumstances which calls for immediate action or remedy; pressing necessity; exigency." All follow-up medical care should be supplied by a physician from the panel, conformed panel (or the authorized treating physician's referral), or from the managed care organization's provider network.

3. Change of Physicians/Treatment

Upon the request of an employee, employer, or insurer/self-insurer, or upon its own motion, the Board may, after notice is given in writing of the request to all interested parties and allowing any interested party 15 days from the date of notice to file written objections to the request, order a change of physician or treatment.

A request for, or objection to request for a change of physician or additional treatment must be filed on a Form WC-200b, with supporting documentation attached and copies must be provided to all parties or their attorneys. In cases that have been designated as "Medical Only", the requesting party must file a Form WC-14 Notice of Claim or a WC-1 along with the Form WC-200b. Parties are required to make a good faith effort to reach a resolution of this issue prior to filing a request with the Board. A mediation conference may be scheduled upon receipt of the request by the Board.

Factors which may be considered in support of the request or objection may include, but are not limited to, the following:

a. Proximity of physician's office to employee's residence

b. Accessibility of physician to employee

c. Excessive/redundant performance of medical procedures

d. Necessity for specialized medical care

e. Language barrier

f. Referral by authorized physician

g. Noncompliance of physician with Board rules and procedures

h. Panel of physicians

i. Duration of treatment without appreciable improvement

j. Number of prior treating physicians

k. Prior requests for change of physician/treatment

l. Employee released to normal duty work by current authorized treating physician

m. Current physician indicates nothing more to offer

If the argument in support of, or objection to, the change is based on testimony, an affidavit must be attached to the form and, if the argument refers to documents, a copy of the documents must be attached.

B. Independent Medical Examination and Evaluation

1. The insurer/self-insurer has the right to request that the injured employee submit to an independent medical examination, which shall include physical, psychiatric, and psychological examinations. An examination may include reasonable and necessary testing, including functional capacity evaluations, as recommended by the examining physician.

2. The insurer/self-insurer shall notify the employee in writing at least 10 days in advance of the time and place of the requested examination. Advance payment of travel expenses as required by Rule 203 (d)(3) shall accompany the notice.

3. The insurer/self-insurer cannot unilaterally suspend income benefits for failure of the employee to attend the scheduled examination. If the injured employee fails to cooperate with the insurer/self-insurer's efforts to schedule an independent medical examination, the insurer/self-insurer may request an order suspending the employee's benefits by filing a motion to suspend on Form WC-102D and attaching appropriate documentation in support of the motion.

4. The employee has a right to an independent medical examination by a physician designated by the employee within 120 days of receipt of income benefits when the requirements of O.C.G.A.§ 34-9-202(e) are met.

C. Payment of Medical Expenses (Board Rule 203(a))

The insurer/self-insurer are responsible for the payment of all reasonable, necessary, and related medical expenses prescribed by an authorized treating physician, including diagnostic testing to determine causation. The insurer/self-insurer may automatically conform charges according to the fee schedule adopted by the Board and shall pay within

30 days from the date of receipt of the charges. Within 30 days of the receipt of medical charges, the insurer/self-insurer must provide written notification to the medical provider of the reasons for non-payment of the expenses and a written itemization of any documents or other information needed to process the claim for medical benefits. The insurer/self-insurer must notify the medical provider in writing within 30 days of the receipt of the charges of the need for further documentation. Failure to do so will be deemed a waiver of the right to defend a claim for failure to pay charges in a timely fashion on the ground that the charges were not accompanied with the proper documentation. However, this waiver does not extend to any other defense the insurer/self-insurer may have with respect to a claim of untimely payment. If the insurer/self-insurer is controverting the medical expenses, they must file a Form WC-3, Notice of Controvert, with the Board within the 30 days allowed for payment. All persons having a financial interest, including the physician, must receive a copy of the Form WC-3.

Medical expenses shall include, but are not limited to, the reasonable cost of travel between the employee's home and the place of examination or treatment, including physical therapy appointments or pharmacy visits. When travel is by private vehicle, the rate of mileage shall be 28 cents per mile. Travel expenses beyond the employee's home city shall include the actual cost of meals and lodging. Travel expenses shall further include the actual reasonable cost of meals when total elapsed time of the trip to obtain outpatient treatment exceeds four hours per visit. Cost of meals shall not exceed $30 per day. Medical expenses include the reasonable cost of attendant care directed by the treating physician during travel and convalescence.

Reasonable medical charges must be paid within 30 days of the date that the insurer/self-insurer receive the charges and reports. If the medical charges are not paid within 30 days of the receipt of the documentation required by the Board, the following penalties will apply automatically: A 10% penalty on reasonable medical charges paid after 30 days but before 60 days; a 20% penalty on reasonable medical charges paid after 60 days but before 90 days; and, in addition to the 20% penalty, a 12% per annum interest rate is charged on reasonable medical charges paid after 90 days. The penalties and interest are payable directly to the provider.

D. Procedure When Amount of Medical Expenses, Necessity of Treatment or Authorized Treatment are Disputed (Board Rules 203(b), 205)

Medical expenses shall be limited to the usual, customary and reasonable charges. Employers/insurers may automatically conform charges according to the fee schedule adopted by the Board and the charges listed in the fee schedule shall be presumed usual, customary and reasonable and shall be paid within 30 days from the date of receipt of the charges. Employer/insurers shall not unilaterally change any CPT-4 code of the provider. All charges that are automatically conformed according to the fee schedule adopted by the Board shall be for the CPT-4 code listed by the provider. In situations where charges have

been reduced or payment of a bill denied, the insurer, self-insurer, or third party administrator shall provide an Explanation of Benefits with payment information explaining why the charge has been reduced or disallowed, along with a narrative explanation of each Explanation of Benefits code used.

Any health service provider whose fee is reduced to conform to the fee schedule may request peer review of charges or treatment and present evidence as to the reasonableness of his/her charges. If the dispute is not resolved through the recommendations of peer review then a mediation or hearing may be requested. An employer/insurer who disputes that any charge is the usual, customary and reasonable charge prevailing in the State of Georgia shall, within 30 days of the receipt of the charges, file with the appropriate peer review committee a request for review of only those specific charges which are disputed. No CPT, DRG, or ICD-9 Codes are to be changed without first notifying, and then obtaining permission from, the authorized treating physician/hospital. Any physician/hospital whose charges are disputed and any party disputing such charges must comply with requirements of law, Board rules, and, if applicable, rules of the appropriate peer review committee before the Board will order payment of any disputed charges. The injured worker's name and address must be included in the request for peer review. Effective July 1, 1992, Board Rule 203(b) was changed to allow all parties to correspond directly with Board approved peer review committees. These committees may be contacted at the following addresses.

Dr. Mitchell S. Nudelman
Medical Director Solutions, LLC
577 Seminole Drive
Marietta, GA 30060
(770) 499-0398 FAX (770) 499-8299

Dr. Eric Krohne, Executive Director
Georgia Chiropractic Association, Inc.
3772 Pleasantdale Road, Suite 175
Atlanta, GA 30340
(770) 723-1100

Ms. Pat Garner, Executive Director
Georgia Psychological Association
1750 Century Circle, Ste. 10
Atlanta, GA 30345
(404) 634-6272 FAX (404) 634-8230

Mr. Marvin Gross, M.S., P.T., Principal
Mr. Stuart Platt, M.S.P.T., P.T., Principal
Appropriate Utilization Group, LLC
1086 Burton Drive

Atlanta, GA 30329
(404) 728-1974

Ms. Ruth Brunder, President
Georgia Home Care Association
168 N. Johnson Street, Suite 304
Dallas, GA 30132
(770) 445-3180 ext. 32

Within 30 days of the date that a decision is issued by a peer review organization, the employer/insurer shall either make payment of disputed charges based upon the recommendations of the peer review committee or request mediation. If the dispute is not resolved through mediation, a hearing may be requested. The peer review committee shall serve a copy of its decision upon the employee, or represented by counsel, on the employee's attorney. A physician whose fee has been reduced by the peer review committee shall have 30 days from the date that the recommendation is mailed to request mediation. If the dispute is not resolved through mediation, a hearing may be requested. In the event of a hearing, the recommendations of the peer review committee shall be prima facie proof of the usual, customary and reasonable charges.

E. Medical Reports

Medical reports shall not be filed with the Board, unless specifically required by a Board rule or otherwise requested by the Board. Do not file miscellaneous medical statements and bills covering items such as drugs, ambulance service, prosthetics. When required by Board Rule 61(b)(12), (15), and (16) or Board Rule 200(c), all medical reports must be filed with the Board within 10 days of the insurer/self-insurer's receipt of same. If a physician attaches a narrative report to a form instead of completing the form, the insurer/self-insurer should complete the employee information and send both to the Board, making certain the narrative report is securely attached to the form. The insurer/self-insurer should, however, encourage physicians to complete the forms. The insurer/self-insurer should always verify the name and address of the employee and the employer, employee's social security number, and the injury date to make certain the information corresponds to that given on the Form WC-1. Do not file miscellaneous medical statements and bills covering items such as drugs, ambulance service, prosthetics.

Form WC-20(a) - Medical Report
(May also file HCFA 1500, HCFC 1450 or UB 92)

The attending physician or other practitioner completes the report to document treatment and forwards it along with office notes and other narratives to the insurer/self-insurer as follows:

1. Within seven days of initial treatment;

2. Upon the employee's discharge by the attending physician or at least every three months until the employee is discharged;

3. Upon the employee's release to return to work; and

4. When a permanent partial disability rating is determined.

The insurer/self-insurer shall file the report including office notes and narratives with the Board as follows:

1. When the report contains a permanent partial disability rating;

2. Upon request of the Board;

3. To comply with other rules and regulations of the Board; and

4. In conjunction with the filing of a Rehabilitation Plan with the Board.

The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports except in compliance with Board Rule 61(b)(12), (15), and (16) and Rule 200(c).

F. Pre-Authorization of Medical Treatment

Although pre-authorization of medical treatment is not required in worker's compensation claims, an authorized medical provider may request advance authorization for treatment or testing by utilizing Board Form WC-205 and faxing or e-mailing this form to the insurer/self-insurer. The insurer/self-insurer must respond within five (5) business days of receipt of the form by completing Section 3 of the Form WC-205 and faxing or e-mailing to the authorized medical provider. If the insurer/self-insurer fails to respond to the WC-205 request within 5 days, the treatment or testing stands pre-approved.

In the event the insurer/self-insurer furnish an initial written refusal to authorize the requested treatment or testing within the five business day period, then within 21days of the initial receipt of the WC-205, the insurer/self-insurer shall either: (a) authorize said requested treatment or testing in writing; or (b) file with the Board a Form WC-3 controverting the treatment or testing indicating the specific grounds for the controversion.

G. Reimbursement of Group Carrier or Other Healthcare Provider

Form WC-206, including supporting documentation, shall be submitted to the Board during the pendency of the claim by the party seeking reimbursement for costs of medical treatment. The party requesting reimbursement must send a copy of the WC-206 to all parties, their counsel, and parties at interest. When the Board receives a request for reimbursement and designation as a party at interest, the Board will provide the party at interest with notice of any hearing or other Board proceeding that has been initiated by a party to the claim.

References: O.C.G.A. §34-9-200
§34-9-201
§34-9-202
§34-9-203
§34-9-205
§34-9-206

Board Rules 61, 200, 201, 202, 203, 205, 206

Chapter 7

REHABILITATION & MANAGED CARE

Introduction

This chapter is to be used in conjunction with and as an adjunct to O.C.G.A. §34-9-200.1 and §34-9-208 and accompanying Board Rules 200.1 and 208. These laws and rules are subject to change on July 1 of every year. It is every rehabilitation supplier's, case manager's, and certified Managed Care Organization's responsibility to maintain knowledge of changing laws and rules regarding rehabilitation and certified MCOs. To order copies of the *Georgia Workers' Compensation Laws, Rules, and Regulations Annotated*, call Lexis Law Publishing at 1-800-542-0957 or contact them on the web at www.lexis.com. This Procedure Manual is also revised yearly. The most recent version is sold for $30.00 at the Board's annual training seminar and afterward by the Board's training division (404-656-5656) as long as supplies last. You may also order the manual using the form at the Board's web site, www.ganet.org/sbwc/information/publications

A. Rehabilitation and Case Management

Rehabilitation suppliers assess, plan, implement, coordinate, monitor and evaluate options and services to meet an injured employee's health care needs. They deliver and coordinate services under an individualized plan; provide counseling; vocational exploration; psychological and vocational assessment; evaluation of social, medical, vocational and psychiatric information; job analysis, modification, development and placement; in addition to other services through communication with the injured employee and others and available resources to promote quality cost-effective outcomes that lead to return to work. Rehabilitation suppliers shall provide these services in a manner consistent with their education and experience and refer to other professionals as appropriate. Rehabilitation suppliers shall serve as an advocate for the injured employee within the confines of the Workers' Compensation Act. Individuals performing any of these functions must be registered with the Licensure and Quality Assurance Division of the State Board of Workers' Compensation as a rehabilitation supplier.

The goal of these services is to restore the injured employee to suitable employment. If this is not possible, then the injured employee should be restored to the highest possible level of physical functioning and to a level of independence similar to that possessed by the employee prior to his or her injury.

Only Board registered rehabilitation suppliers shall perform the activities outlined herein. However, direct employees of insurers, third party administrators and employers may perform a portion of these activities in the administration of their workers' compensation claims. Other rehabilitation suppliers not registered with the Board, or any person performing any of the activities described in Rule 200.1(a)(1)(i), (ii) who are not direct employees of insurers, third party administrators or employers, or any person who violates

the provisions of Board Rule 200.1 shall be subject to civil penalties in accordance with O.C.G.A. §34-9-18. Complaints must be received in writing to the Division Director of Managed Care and Rehabilitation at the Board. An investigation of the complaint will be conducted to determine if a hearing should be scheduled.

O.C.G.A. §34-9-200.1 requires the employer/insurer to provide rehabilitation services that are reasonable and necessary to catastrophically injured employees. For cases with dates of injury on or after July 1, 1992, catastrophic injury is defined in O.C.G.A. §34-9-200.1(g) as follows:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;
2. Amputation of an arm, hand, foot, or leg involving the effective loss of use of that appendage;
3. Severe brain or closed head injury as evidenced by:
    a. Severe sensory or motor disturbances
    b. Severe communication disturbances
    c. Severe complex integrated disturbances of cerebral function
    d. Severe disturbances of consciousness
    e. Severe episodic neurological disorders;
    f. Other conditions at least as severe in nature as any condition provided in subparagraphs (a) through (e) preceding this paragraph
4. Second or third degree burns over 25 per cent of the body as a whole, or third degree burns to five per cent or more of the face or hands
5. Total or industrial blindness
6. Any other injury of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy for which such employee is otherwise qualified. A decision granting or denying disability income benefits under Title II or supplemental security income benefits under Title XVI of the Social Security Act shall be admissible in evidence and the Board shall give the evidence the consideration and deference due under the circumstances regarding the issue of whether the injury is a catastrophic injury.

Please see the Appendix, ***Information Required to Process Requests for Catastrophic Designation,*** at the end of this chapter for the procedure to follow when filing a request for catastrophic determination of a claim. All requests for catastrophic determination shall be submitted to the Division of Managed Care and Rehabilitation.

B. Appointment of a Board Registered Catastrophic Rehabilitation Supplier

1. In any catastrophic injury case, the employer/insurer shall designate a Board registered catastrophic rehabilitation supplier within 48 hours of accepting the injury as compensable, or notification of a final determination of compensability, by filing a Form WC-R1 (Request for Rehabilitation) with the Board. This may occur

simultaneously with the filing of the Employer's First Report of Injury (Form WC-1) or within 15 days of notification that rehabilitation is required. If the employer/insurer does not file the Form WC-R1, or catastrophic designation is being requested by the employee or the employee's attorney, the employee shall file a Form WC-R1CATEE to request catastrophic designation and the appointment of a catastrophic supplier. The requesting party shall send copies of the Form WC-R1CATEE to all parties and the supplier and complete the certificate of service on the Form WC-R1CATEE. The requesting party shall also attach all documentation required for the review process to determine catastrophic designation. Please see the Appendix at the end of this chapter, ***Information Needed to Process Requests for Catastrophic Designation,*** for a list of information needed by the Board to process requests for catastrophic designation. If the employer/insurer does not appoint a designated catastrophic supplier timely, and the Board determines rehabilitation is necessary, the Board may appoint a catastrophic supplier and notify all parties and the involved supplier.

2. For cases with dates of injury prior to July 1, 1992, unless excused by the Board, any case party shall file a Form WC-R1 with the Board at any time for the designation of a rehabilitation supplier. For all dates of injury, the Board recognizes the following as case parties: employee, employer, insurer, servicing agent or third party administrator if there is one on the case, counsel for employee, counsel for employer/insurer, Subsequent Injury Trust Fund if there is a reimbursement agreement or order, and counsel for the Subsequent Injury Trust Fund if counsel has been assigned. ***Rehabilitation suppliers and case managers are not considered to be case parties.*** The Forms WC-R1 and WC-R1CATEE are used to request initial appointment. The Form WC-R1 is also used to reopen rehabilitation. The request shall include pertinent medical information available concerning the injured employee, as well as a statement supporting the need for rehabilitation services. The requesting party shall complete and send copies of the Form WC-R1 or WC-R1CATEE to all parties and the supplier and complete the certificate of service on the Form WC-R1 or WC-R1CATEE. If the Board deems a rehabilitation supplier is needed and no party has requested appointment, the Board may appoint a supplier and will notify all parties and the involved supplier.

3. For claims with dates of injury prior to July 1, 1992, the injured employee may be eligible for rehabilitation services if, in the judgment of the Board, those services are likely to return the employee to suitable employment consistent with the employee's prior occupational level and/or will restore the employee to optimal physical functioning.

4. Reporting to the Board on rehabilitation cases is required only if the injury or case is designated as catastrophic or if the injury occurred prior to July 1, 1992. Reporting to the Board on voluntary rehabilitation/case management cases is allowed, but not required.

5. For suppliers who meet additional education and experience criteria, the Board may assign a catastrophic designation. Only rehabilitation suppliers/case managers who are registered with the Board as catastrophic rehabilitation suppliers shall be assigned as rehabilitation suppliers/case managers to the cases of injured employees whose injuries have been designated as catastrophic. If a supplier who does not hold the catastrophic designation is assigned to work with an injured employee, and then discovers that the employee's injuries are catastrophic in nature, ***it is the supplier's responsibility to notify the Board and all case parties of the situation.***

6. In the event rehabilitation services are being voluntarily provided by agreement of the parties, and the case is subsequently determined to be catastrophic secondary to the provisions of O.C.G.A §34-9-200.1(g)(6), the employer/insurer shall file a Form WC-R1 to designate a catastrophic supplier.

C. Rehabilitation Supplier Duties in Catastrophic Cases: Plans; Non-Catastrophic Medical Care Coordination of Pre-July 1, 1992 Cases; Non-Catastrophic Medical Care Coordination for Dates of Injury On or After July 1, l992 (Voluntary Cases)

1. Rehabilitation Supplier Duties

The Board registered rehabilitation supplier shall have sole responsibility for each individual case. The rehabilitation supplier shall complete, with the injured employee, the initial rehabilitation evaluation within 30 days of appointment to the case. The catastrophic rehabilitation supplier shall also complete, in person with the employee, an appropriate plan of services on Form WC-R2A within 60 days of appointment to the case. The case may be closed after the initial rehabilitation assessment, when appropriate.

Initial evaluation means a personal interview between the employee and approved catastrophic rehabilitation supplier. The rehabilitation supplier reviews the medical and other records to determine if the employee is in need of rehabilitation services and the feasibility of providing rehabilitation services. The written evaluation report shall provide the supplier's conclusion as to why the employee would or would not benefit from rehabilitation services, and provide an indication of what further services are needed.

A Board-registered rehabilitation supplier may obtain specific services from another qualified individual, facility, or agency for direct services outside the scope of expertise of the supplier upon Board approval of a plan that specifies such services.

The registered rehabilitation supplier shall complete, sign and file all rehabilitation reports with the Board as required by the rules, and send copies of those reports,

as well as any available medical reports, simultaneously to all case parties, as soon as the supplier creates or receives such reports. ***All correspondence should include the supplier's registration number.*** The employee's attorney may accept service of the employee's copy.

The written initial rehabilitation report shall include at least the following information, whether the report is written by a counselor or a nurse, and shall always be submitted along with the first Form WC-R2 (transmittal report) or Form WC-R2A (proposed rehabilitation plan) submitted to the Board, within 60 days of the supplier's appointment to the case:

(a) Summary of current medical status, secondary conditions affecting recovery, treatment, prognosis and estimate of time frames, if possible;
(b) Employer contact (specify name and title) regarding return to work possibilities, including same job, modified job, different job, graduated return to work, or termination;
(c) Social history;
(d) Educational background;
(e) Employment history;
(f) Average weekly wage at the time of injury;
(g) Transportation availability;
(h) Summary of positive and negative indicators for return to work; and
(i) Statement of supplier's conclusion regarding the employee's need for rehabilitation services and the likelihood of whether the employee will benefit from further rehabilitation services.

2. Plan Submission; Objections; Approval

In all catastrophic injury cases, and for injury cases with dates of injury before July 1, 1992, when the employee is ready for vocational or "prevocational" (such as labor market surveys) services, the registered rehabilitation supplier shall submit a proposed Individualized Rehabilitation Plan (Form WC-R2A) to the Board, copied to all parties, within 60 calendar days of the supplier's appointment. The proposed plan shall include goals, justification for goals, objectives to achieve goals, dates for completion of objectives, delineation of responsibilities of the parties involved, and estimated rehabilitation costs to complete the plan. The objectives shall be stated in measurable terms and shall be related to the established goal. The proposed plan will include documentation of the participation of the employee in person in the development of the rehabilitation plan including comments, if any, regarding opposition to the plan, and will be signed by the employee or his/her attorney.

See Board Rule 200.1(b)(3) and (c) for procedures regarding approvals and objections.

Unless excused by the Board, for catastrophic injury cases, after the initial plan is approved, the supplier shall submit progress reports, with updated medical reports and supporting documentation, every 90 days under cover of a Form WC-R2. ***Catastrophic-injury cases are to be covered by a current plan at all times; Forms WC-R2 are to be filed every 90 days in between submitted proposed rehabilitation plans.*** Medical care coordination and independent living plans, (which are not allowed in non-catastrophic injury cases with dates of injury prior to July 1, 1992) as well as extended evaluation, return to work, training, and/or self employment plans may be written for catastrophically-injured employees. The first proposed rehabilitation plan is due to the Board within 60 days of the rehabilitation supplier's appointment.

See Board Rule 200.1(a)(5) for types and descriptions of plans, as well as maximum time frames for each type of plan.

Extended evaluation plans (written for no more than one year) are for the purpose of ascertaining if vocational rehabilitation is feasible, and if so, to identify specific job goals. Often labor market surveys, vocational evaluations, and functional capacity evaluations are services proposed in this type of plan.

All return to work situations, whether to the employer of injury or to a new employer, are to be covered by a return-to-work plan submitted by the assigned rehabilitation supplier. Such plans should clearly document the expectations and requirements of both the employee and the employer. The plan should be accompanied by a current release to return to work from the authorized treating physician(s) and an approved job description or analysis of the job to which the employee is returning. Return-to-work plans are written in the following order (the "return-to-work hierarchy"):

1) return to work with the same employer;
2) return to different job with same employer;
3) return to work with new employer;
4) short-term training;
5) long-term training;
6) self-employment.

In some catastrophic injury cases, parties may agree that training is the most efficient way to return an employee to work, and the employee may be able to begin training while recovering from his or her injury. In most cases, however, the feasibility of direct placement must be considered first, and then ruled out, before a training plan can be written. Likewise, short-term training must be considered before a plan for long-term training. The rehabilitation supplier shall document the reason a specific type of plan is proposed, and why another type of

plan, earlier in the hierarchy, is not feasible. The return-to-work plan shall be in place for no longer than a one-year period.

All job search plans should be accompanied by documentation of labor market surveys or other information which documents a reasonable possibility of suitable employment in the job objectives listed on the plan. The plan must be submitted along with a current release to return to work from the authorized treating physician(s). Employment goals should be reasonably consistent with the employee's prior vocational status, including average weekly wage, as well as within the employee's current physical abilities. All treating physicians must concur that the employee is released to return to work.

Training plans should be submitted only when direct placement (placement with the employer of injury or with another employer) is not possible or feasible, unless all parties agree to training. If this is the case, it should be clearly documented on the proposed training plan. All training plans shall be submitted with complete documentation of the proposed training program, including its length and total cost, and should include a provision that the employee must maintain at least passing grades for the plan to continue. Training plans are in place for no more than one year.

Self-employment plans are submitted only when direct placement and training plans are documented as not possible or feasible. The self-employment plan must further document that the proposed type of self-employment is likely to be successful. An extended evaluation may assist in determining success in self-employment.

Medical Care Coordination and Independent Living plans are to be submitted only in cases of catastrophic injury. These plans must address the employee's comprehensive rehabilitation and medical needs, including suitable housing and transportation. Medical Care Coordination plans and independent living plans are in place for no longer than one year.

The rehabilitation supplier shall always submit whatever type of rehabilitation plan the supplier believes, in his or her professional judgment, is most appropriate at the time, irrespective of any case party's opinion on the matter. Any party may object once the plan is submitted to the Board, and the Board will issue a decision on the matter and/or hold a conference to discuss it. Should the supplier propose a plan of services that the employee (or his attorney) refuses to sign, the supplier should request a rehabilitation conference or advice from the Board's Rehabilitation Coordinator. The rehabilitation supplier shall submit a copy of the proposed plan as well as all available information that has not been previously submitted to the Board, including any objections voiced by the employee or his/her representative.

3. Non-catastrophic Medical Care Coordination – Pre July 1, 1992

For cases with dates of injury prior to July 1, 1992, when a rehabilitation plan is not appropriate because the employee is not yet medically stable enough to proceed to vocational planning or services, the registered rehabilitation supplier shall submit a report of proposed medical care coordination services for non-catastrophic cases by filing Form WC-R2 with the Board copied to all parties with a certificate of service within 60 days of appointment to the case. The report shall include the initial evaluation report, recent medical reports, and an outline of services that the rehabilitation supplier will provide to resolve existing and potential problems that interfere with the physical recovery.

In such cases, the registered rehabilitation supplier shall submit progress reports with Form WC-R2 if the status changes, at the request of the Board, or at least every 26 weeks, as long as the rehabilitation supplier is providing only medical care coordination services. The rehabilitation supplier shall prepare and submit a proposed plan of vocational rehabilitation services when the physician has recommended vocational rehabilitation activities; the injured worker is medically stable and ready to begin the return to work process; the physician has provided physical guidelines and/or a release to return to work; and there appears to be a reasonable chance vocational services will enable the injured worker to return to suitable employment.

4. Non-Catastrophic Medical Care Coordination – Voluntary Cases

For employees injured on or after July 1, 1992, whose injuries are not catastrophic in nature, rehabilitation services may be provided on a voluntary basis if all parties agree in writing, for so long as such agreement continues. All suppliers providing rehabilitation services in such cases are required to register with the Licensure and Quality Assurance Division of the Board. Refer to Board Rule 200.1(h), regarding documentation of agreement for voluntary rehabilitation and case management, withdrawal of agreement, and supplier responsibilities and services allowed after withdrawal of agreement.

Rehabilitation suppliers shall avoid initiating or continuing consulting or counseling relationships with an injured employee when the injured employee can no longer reasonably be expected to benefit from further services or is unwilling to accept further services. The rehabilitation supplier should complete an initial evaluation of the injured employee as soon as possible after the voluntary agreement has been completed. The rehabilitation supplier should propose and review an appropriate plan of services so that all parties will be aware of the services to be rendered.

Rehabilitation suppliers shall function within the limitations of their role, training, and technical competency. In the event the needs of the injured employee exceed the rehabilitation supplier's role or competence, the injured employee shall be referred to a specialist as the needs of the injured employee dictate.

A rehabilitation supplier may contract with an employer/insurer or attorney to review files, give recommendations regarding case management, safety and rehabilitation issues, and perform job analyses of employment positions. All recommendations and reviews must be submitted directly to the employer/insurer or its agent requesting rehabilitation services. Rehabilitation suppliers retained for these purposes shall not communicate, in person or in writing, with the injured employee, the employee's attorney, or the employee's authorized treating physician without prior written consent of the injured employee. The supplier shall clearly define to all parties the limits of his or her relationship as a consultant and shall provide unbiased, objective opinions.

Rehabilitation suppliers registered with the Board and providing services in voluntary cases may contact the Board's Rehabilitation Coordinators for technical assistance at any time during their case work.

D. Communications in All Rehabilitation Cases

A rehabilitation supplier shall provide copies of all correspondences simultaneously to all parties and their attorneys. A rehabilitation supplier shall provide adequate information to all parties and providers regarding the medical treatment and condition of the injured employee. Rehabilitation suppliers recognize the employee's attorney as the employee's representative.

The rehabilitation supplier shall provide professional identification and shall explain his or her role to the physician at the initial contact with the physician. In all cases, the rehabilitation supplier shall advise the injured employee that he or she has the right to a private examination by the medical provider outside the presence of the rehabilitation supplier.

The rehabilitation supplier shall not obtain medical information regarding an injured employee in a personal conference with the physician following an examination, unless the rehabilitation supplier has reserved with the physician sufficient appointment time for the conference and the injured employee and his or her attorney were given prior reasonable notice of their option to attend the conference. If the injured employee or the physician does not consent to a joint conference, or if in the physician's opinion it is medically contraindicated for the injured employee to participate in the conference, the rehabilitation supplier shall note this in his or her report and may in those specific instances communicate directly with the physician. The rehabilitation supplier shall report to all

parties and the employee's attorney the substance of the communication between him or her and the physician. Exceptions to the notice requirement may be made in cases of medical necessity or with the consent of the injured employee or his or her attorney. The rehabilitation supplier shall simultaneously send copies to all parties of all written communications to medical care providers.

Please see Board Rule 200.1(a)(6)(i)-(viii) for a more detailed explanation of suppliers' responsibilities and communications.

E. Rehabilitation Case Closure

The registered rehabilitation supplier shall submit Form WC-R3, Request for Rehabilitation Closure, with certificate of service completed as indicated on the form, when:

1. The supplier believes that rehabilitation is no longer needed or feasible;
2. The employee has successfully returned to full-time work for at least 60 days and is no longer in need of the supplier's services;
3. A stipulated settlement which does not include further rehabilitation services has been approved; or
4. The Board has issued a decision closing rehabilitation.

In catastrophic-injury cases, rehabilitation may remain open after the employee has returned to work for 60 days, if the employee would benefit from further medical care coordination by the supplier. On all Form WC-R3s submitted for closure, the supplier is required to complete Section V.

Regardless of any case party's opinion, the rehabilitation supplier is responsible for requesting closure of rehabilitation whenever his or her professional opinion is that rehabilitation is no longer needed or feasible. If the supplier is unsure if a case should be closed, he or she may write to the Board's Rehabilitation Coordinator and request an opinion on the issue. If an objection to closure is received from a case party, the Board's Rehabilitation Coordinator will issue an administrative decision.

Upon review of the file at any time, the Board may determine that closure is appropriate and may issue an administrative decision to close rehabilitation.

A case party may request in writing that the Board close rehabilitation. The party must complete a certificate of service stating that copies of the request for closure were sent to all parties and any involved rehabilitation supplier. The closure request must include specific reasons for closure. If an objection is filed, the Board's Rehabilitation Coordinator will issue an administrative decision.

F. Change of Registered Rehabilitation Supplier

On any mandatory rehabilitation case, changes in rehabilitation suppliers may be requested only by parties to the case and shall only be made by approval of the Board. The Form WC-R1 requesting a change in supplier shall include the name and address of both suppliers and the specific reasons the change is requested. The requesting party shall send copies of the Form WC-R1 to all parties and both suppliers and complete the certificate of service on the Form WC-R1. WC-R1 forms which do not comply will be returned to the party making the request. If the Board determines that a rehabilitation supplier should be removed from a case and the Board determines that rehabilitation is still needed, the Board may direct a change of supplier and will notify all parties and involved rehabilitation suppliers of this decision.

In the event of a request for a change of registered rehabilitation supplier, the Board designated rehabilitation supplier shall maintain responsibility for providing necessary rehabilitation services, unless excused by the Board, until all appeals have been exhausted.

G. Approval and Objections

For all rehabilitation requests, absent written objections to the Board, copied to all parties and involved rehabilitation suppliers, within 20 days of the date of the certificate of service on the Form WC-R1, the request for rehabilitation assessment or services is approved and no further correspondence will be issued by the Board.

The Board* will *issue decisions on all Requests for Catastrophic Designation on a Form WC-R1CATEE, even if no objections are received. In those cases, the supplier named in the initial request for catastrophic designation shall not provide rehabilitation services unless or until a decision is issued naming him or her as the rehabilitation supplier, or a new Form WC-R1 is filed by the employer/insurer, appointing that supplier.

Refer to Board Rule 200.1(b)(3) and (c) for specific information regarding objections and the appeals process.

H. Employee Failure to Cooperate

An employer/insurer's application to suspend or reduce an employee's income benefits for failure to cooperate with mandatory rehabilitation shall be filed with the Board on Form WC-102D, outlining its contentions and requesting an order on that issue. The employer/insurer may suspend or reduce weekly benefits for refusal of the employee to accept rehabilitation as awarded by the Board only by order of the Board.

A case party may wish to request a rehabilitation conference prior to filing a motion to request suspension of income benefits.

I. Failure of a Party or Counsel to Cooperate

A party or attorney may be subject to civil penalty or to fee suspension or reduction for failure to cooperate with rehabilitation services. Failure to cooperate may include, but is not limited to, the following:

(1) Interference with the services outlined in a Board-approved rehabilitation plan;
(2) Failure to permit an interview between the employee and supplier within 10 days of a request by the supplier or other obstruction of the interview process without reasonable grounds;
(3) Interference with any party's attempts to obtain updated medical information for purposes of rehabilitation planning;
(4) Failure to return the proposed rehabilitation plan to the supplier within 15 days of receipt or give objections to the plan within 20 days; or
(5) Failure to attend a rehabilitation conference without good cause.

J. Board Conferences/ Supplier Role in Settlement Mediations

1. Board Conferences

As requested by a case party, rehabilitation supplier, or Administrative Law Judge, or if the Rehabilitation Coordinator determines there is a need for a conference, the Board may schedule a mediation or administrative rehabilitation conference to resolve problems interfering with the rehabilitation process. The parties should make all efforts to resolve the problem before requesting a conference. The Rehabilitation Coordinator may try to resolve the problem in other ways before scheduling a conference. All parties and the supplier may be required to attend, or be represented, at Board conferences. If required and a party fails to attend or to send a representative, then the conference may be held or canceled at the discretion of the Rehabilitation Coordinator. Rehabilitation conferences differ from mediation in that the Rehabilitation Coordinator may issue an administrative decision or recommendation memorandum after a conference, even if no agreement is reached. These documents are sent to all case parties and involved rehabilitation suppliers and become part of the Board file.

See Board Rule 200.1(e)(3) for responsibilities of rehabilitation suppliers and case parties to attend rehabilitation conferences, and possible penalties for failing to do so. Rehabilitation conferences can succeed only if all parties are either present or represented by individuals who have full authority to decide all disputed rehabilitation issues.

2. Rehabilitation Suppliers' Role in Settlement Mediations

When the Board approves a settlement agreement in a catastrophic injury claim, the rehabilitation needs of the injured worker must be considered. When the ADR Unit of the Board schedules a settlement mediation conference, all aspects of an injured worker's claim will be addressed. As the future rehabilitation needs of the injured worker are one of the issues that must be addressed, input from the rehabilitation supplier is often valuable. As such, the Board's preference is for the supplier to attend the settlement mediation if possible.

Usually, the mediator will excuse the supplier after the supplier gives his/her input. The supplier may give a number where the supplier can be reached if questions arise after the supplier's departure. The employer/insurer or self-insurer shall be responsible for paying reasonable costs for the supplier to attend settlement mediations on catastrophic injury cases.

However, the role of a rehabilitation supplier should be limited solely to the rehabilitation aspects of the case. When asked by the mediator, the rehabilitation supplier should give input on the employee's future medical and rehabilitation needs, including costs of future medications, projected surgeries, orthotics, prosthetics, training programs, attendant care, and other rehabilitation and medical expenses. A rehabilitation supplier should never become involved in negotiations regarding how much an injured worker's case should settle for, or whether or not the injured worker should settle. If the injured worker queries the supplier, the supplier should refer the worker to his or her attorney, or to the Board if the worker is not represented.

K. Code of Ethics

Each rehabilitation supplier and case manager shall comply with the professional standards and code of ethics as set forth by his or her certification or licensure board. Rehabilitation suppliers shall not provide rehabilitation services until registered with the Board. Case managers operating under a certified managed care organization pursuant to O.C.G.A. §34-9-208 and Board Rule 208 are not subject to Board Rule 200.1 if the case manager is providing services for an employer with a posted WC-P3 W/C MCO panel (§34-9-201(b)(3)). Problems or questions concerning ethics should be addressed to the rehabilitation suppliers licensure board. Violations of Board Rule 200.1 shall be addressed to the Managed Care and Rehabilitation Division of the State Board of Workers' Compensation, unless the information is protected by law.

L. Appropriate Services/Disputed Charges/Rehabilitation Peer Review

Rehabilitation suppliers shall provide appropriate services as needed to return the injured worker to suitable employment consistent with prior occupational levels or to restore the injured worker to optimal physical functioning. Rehabilitation expenses shall be limited to the usual, customary and reasonable charges prevailing in the State of Georgia. The

charges shall be paid within 30 days from the date of receipt of the charges. When the payor disputes the charges, the payor shall file a request for peer review, within 30 days of receipt of the charges, with the rehabilitation peer review organization. Thereafter, the payor may request a mediation conference by filing a Form WC-14 with the Board. Peer review is outlined in the Rehabilitation Fee Schedule.

M. Rehabilitation Supplier, Case Manager Qualifications and Registration

Rehabilitation suppliers must be certified or licensed as one of the following: Certified Rehabilitation Counselor (CRC), Certified Disability Management Specialist (CDMS), Work Adjustment and Vocational Evaluation Specialist (WAVES), Certified Rehabilitation Registered Nurse (CRRN), Licensed Professional Counselor (LPC), Certified Case Manager (CCM), Certified Occupational Health Nurse (COHN or COHN-S). Case managers providing services pursuant to O.C.G.A. §34-9-208, 34-9-201(b)(3), and Board Rule 208 are exempt from this registration requirement, as they are approved through the certification process of the managed care organization. Any individual who holds one of the certifications or licenses listed above, regardless of residence, may become registered as a Georgia Workers' Compensation rehabilitation supplier.

Only Board registered suppliers shall be designated as rehabilitation suppliers. Any rehabilitation counselor or nurse who is not registered with the Board as a rehabilitation supplier pursuant to Rule 200.1 will not be eligible to serve as the registered rehabilitation supplier for any Georgia Workers' Compensation rehabilitation case.

If an injured employee does not live in Georgia or a state adjoining Georgia, the assigned rehabilitation supplier or case manager may associate a counselor or nurse who lives near the employee to assist with rehabilitation. However, the Board registered assigned supplier in mandatory cases will maintain sole responsibility for the case, all rehabilitation services, reporting to the Board on the case, and must perform personally the initial interview and plan development interviews. The assigned supplier may submit the associated counselor or nurse's reports along with his or her own reports and required forms.

N. Catastrophic Rehabilitation Supplier Qualifications; Procedure for Applying to Become a Catastrophic Rehabilitation Supplier

The State Board of Workers' Compensation encourages rehabilitation suppliers to complete the requirements to become registered as catastrophic rehabilitation suppliers. These requirements are intended to ensure that all registered catastrophic rehabilitation suppliers have a standard knowledge base, are familiar with the documents which control their provision of rehabilitation services to injured employees, and work according to their licensing and/or certifying bodies' Standards of Practice and Codes of Ethics.

Applying to become a registered catastrophic rehabilitation supplier is an ongoing, proactive process. Rehabilitation suppliers who wish to apply for catastrophic registration must notify

the Board's Managed Care and Rehabilitation Division of their intent to do so, *before beginning to accrue the required training and experience*. After initial notification to the Board, the applicant will then submit proposals to and receive feedback from the Catastrophic Certification Committee, on an ongoing basis. This committee consists of a group of peers (registered catastrophic rehabilitation suppliers). The Committee reviews all catastrophic supplier applications and application components to ensure that all applicants' experience and education are of the highest quality and relevant to providing effective rehabilitation services for catastrophically injured employees.

Before Applying:
Before **beginning** to accrue the required training and experience to become a registered catastrophic rehabilitation supplier, an applicant shall have been registered with the State Board of Workers' Compensation as a Georgia rehabilitation supplier for a minimum of two years immediately prior to the beginning of the catastrophic application process. The applicant shall notify the Board at the time he or she decides to begin the process of applying to become a catastrophic rehabilitation supplier.

How to Notify the Board of Intent to Apply for Catastrophic Registration:
A rehabilitation supplier who wishes to begin the process to apply for catastrophic registration shall complete a form, ***Notification of Intent to Apply to Become a Registered Catastrophic Rehabilitation Supplier*, found as an Appendix to Chapter 7** of the Board's Procedure Manual. The form may also be obtained by contacting the Board's Managed Care and Rehabilitation Division at (404) 656-0849. The applicant shall submit the completed form to this Division. She/he shall certify that he or she has been registered with the Board as a rehabilitation supplier for at least two years immediately preceding this notification, as well as specifying which license(s) or certification(s) s/he holds.

The supplier shall also be required to state on the form

- that s/he has read and has access to a copy of the Standards of Practice and Codes of Ethics of all of his/her licensing or certifying bodies
- that s/he will abide by those Codes of Ethics and Standards of Practice.
- that s/he has read and has access to O.C.G.A. § 34-9-200.1, Board Rule 200.1, and Chapter 7 of the Board's Procedure Manual
- that s/he realizes that O.C.G.A. §34-9-200.1, Rule 200.1, and the Board's Procedure Manual may change yearly, and that it is his/her responsibility to stay abreast of those changes.

Applying to become a registered catastrophic rehabilitation supplier is an ongoing, proactive process. Prior to each component of required training or experience, the applicant should submit a separate completed proposal on the form, ***Catastrophic Supplier Applicant's Proposal Form for Observation/Experience Component*** for each disability area of proposed experience, and should only submit one proposal at a time. Each proposal should be submitted through the Board's Managed Care & Rehabilitation Division, to the

Catastrophic Certification Committee. Hours obtained will not count unless the proposal is approved by the Catastrophic Certification Committee. The Committee will approve, reject, or modify each proposal within 60 days of receipt, and will notify the applicant.

A total of 190 hours is required for catastrophic registration, divided as explained below:

REQUIRED TRAINING AND EXPERIENCE (190 HOURS TOTAL)

a. Experience: (150 hours total, 50 hours each in three different disability areas)

Each applicant for catastrophic rehabilitation supplier registration shall document at least 50 hours of experience or observation, which may be either paid or volunteer, in ***each*** of **three** of the following disability areas: spinal cord injury, amputation, catastrophic brain injury, burns, blindness. The experience does not have to be in Georgia Workers' Compensation cases. It is the responsibility of each applicant to find and develop his/her own observation/experience opportunities.

For each disability area chosen, the catastrophic applicant shall choose an inpatient or outpatient facility, program, or professional health care provider specializing in provision of services to individuals with that disability. The applicant shall obtain written consent to observe and/or provide services at that facility or with that health care professional.

For each disability area, the applicant shall observe and/or provide services (paid or volunteer) for at least 40 hours. Required paperwork will count for the other ten required hours. The applicant may observe several individuals with the disability, and all of the observation/service provision hours may be counted (once the proposed experience component has been approved). The applicant shall choose one individual with the disability for whom the required initial rehabilitation report, narrative justification for plan, and proposed rehabilitation plan shall be submitted, as though that person were a workers' compensation client, even if he or she is not.

For each experience component, the applicant shall have both an onsite supervisor who shall verify the hours the applicant has spent in observation/experience, and a Rehabilitation Mentor.

Before any experience can count toward catastrophic registration, the applicant must submit a proposal which shall outline

- where the applicant plans to obtain training and/or experience
- which disability is being studied
- what onsite supervisor will monitor and verify the times, dates, and hours which the applicant spent at the facility or program

- an on-site supervisor may only serve in that capacity for a maximum of two of the observation/experiences
- who his/her Catastrophic Rehabilitation Mentor shall be for each experience
- a Catastrophic Rehabilitation Mentor may serve in that capacity for all three observation/experiences

A Catastrophic Rehabilitation Mentor is an individual who has been a Board-registered catastrophic rehabilitation supplier for at least two years, and who has agreed to serve as a telephonic mentor/consultant to the applicant mentoring an experience the applicant is using toward catastrophic registration. The applicant may, but is not required to, have a different Rehabilitation Mentor for each experience component. The Board will send the applicant, upon receipt of the form, *Notification of Intent to Apply for Catastrophic Rehabilitation Supplier Registration,* a list of all catastrophic suppliers who have agreed to serve as Mentors. It is the responsibility of the applicant to find his or her own Mentor(s) from this list; or have a qualified certified catastrophic rehabilitation supplier contact the Board's Managed Care & Rehabilitation Division to have their name added to the list. A Rehabilitation Mentor may accept or refuse to mentor any observation/experience component, at the Mentor's discretion. The applicant and Mentor shall staff each experience at least weekly by telephone. The applicant and Rehabilitation Mentor shall also staff the case of the client for whom the applicant will submit the required reports and proposed rehabilitation plan, on at least a weekly basis.

After receiving approval from the Catastrophic Certification Committee, the applicant shall begin his/her proposed experience/observation. S/he shall staff the case at least weekly by telephone with his/her Mentor. During or after each experience/observation, the applicant shall complete the following documentation on the client the applicant has chosen for required paperwork. The applicant shall not use the client's real name or social security number on the submitted forms and reports:

- An initial report*****
- A proposed rehabilitation plan on official board form WC-R2A*
- A narrative report including the injured individual's medical status, history of the case, and rationale for each of the proposed services in the plan*

***All written as though the affected individual were an injured employee.**

- A brief record of all consultations with his or her Mentor, including the dates and topics of discussion; and a brief signed statement from the mentor attesting that this is an accurate summary.
- A statement signed by the on-site supervisor named in the applicant's original proposal, documenting the times, dates, and hours that the applicant spent in the program.

After completion of the experience required for each separate disability, the applicant

shall submit the completed form, ***Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant*** along with all of the required documentation for that component, through the Board's Managed Care and Rehabilitation Division, to the Catastrophic Certification Committee. This committee meets quarterly (**refer to the Division's web page on the Board's web sight, www.ganet.org/sbwc, for specific meeting dates).** To be considered at a meeting, the documentation must be submitted at least thirty (30) days prior to the scheduled meeting date. The Catastrophic Certification Committee will review the documentation at the meeting and will respond to the applicant within sixty (60) days. The Catastrophic Certification Committee may require revision of an applicant's initial report, narrative, and proposed rehabilitation plan before awarding final credit for each component. Once this component is approved by the Catastrophic Certification Committee, it will count toward the applicant's eventual catastrophic supplier registration.

b. Training (40 hours required)

In addition to the observation/work/volunteer experiences noted above, the catastrophic applicant shall document completion of 40 training hours relevant to catastrophic rehabilitation.

All training must be relevant to catastrophic injury medical issues, and/or catastrophic rehabilitation and case management. Topics may include spinal cord injuries, amputations, catastrophic brain injuries, burns, blindness, accessible housing and workplace design, and/or suitable transportation for individuals with catastrophic disabilities. The 40-hour internship at the Roosevelt Warm Springs Institute for Rehabilitation (RWSIR) is pre-approved. The applicant should call Warm Springs directly at 706-655-5233 to make arrangements to attend. Once the applicant has completed the RSWIR internship, s/he shall send to the Board's Managed Care and Rehabilitation Division a copy of the completed form signed by the RWSIR professionals certifying his/her attendance at all of the sessions as well as the completed Board Form, ***Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant***.

An applicant may obtain pre-approval for other proposed training by submitting the Board form, ***Catastrophic Supplier Applicant's Proposal Form for Training*** to the Catastrophic Certification Committee, via the Board's Managed Care and Rehabilitation Division, for review. Preference will be given to in-depth training of at least one day's duration. The Catastrophic Certification Committee will respond to an applicant's request for pre-approval for a training component within 30 days of receipt of the proposal.

If an applicant has an opportunity for **relevant** training before there is time to obtain pre-approval from the Committee, the applicant may elect to attend the training without

pre-approval; however, the applicant understands that s/he is **taking the risk** that the training may not be approved. No more than two training days (a maximum of sixteen (16) hours) of non pre-approved training may be submitted. The applicant shall submit the training for approval on the Board Form, ***Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant*** as soon as possible.

See the following appendices to this chapter, related to this section:

Flow Chart for Applying to Become a Registered Catastrophic Rehabilitation Supplier

Notification of Intent to Apply to Become a Catastrophic Rehabilitation Supplier

Catastrophic Supplier Applicant's Proposal Form for Observation/Experience Component

Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant

Catastrophic Supplier Applicant's Proposal Form for Training

Documentation of Training Attended by Catastrophic Supplier Applicant

O. Application, Registration, Renewal, Denial of Applications, Revocation

See Board Rule 200.1(f)(1) for information regarding application, registration, renewal, appeal process, disciplinary actions against a supplier, and revocation or suspension of registration.

To register as a rehabilitation supplier or rehabilitation resident, an applicant shall submit a completed, notarized, application form, a copy of his or her applicable licenses and/or certifications (CRC, CDMS, CRRN, CWAVES, LPC, CCM, COHN, COHNS), and a registration fee of fifty dollars ($50.00) to the Board's Licensure and Quality Assurance Division.

The registration shall be renewed annually. An applicant shall submit a completed renewal application form, a renewal fee of twenty-five dollars ($25.00), and documentation of current certification. Rehabilitation suppliers registered prior to July 1, 1985, who are not certified by CRC, CDMS, WAVES, LPC, CCM, COHN, COHNS or CRRN shall continue to renew registration annually. The renewal application for uncertified rehabilitation suppliers shall be accompanied by evidence of at least 30 contact hours of continuing education units that have been approved by one of the certifying

Boards. Not later than the 30th day of November, the certified and uncertified rehabilitation supplier shall submit an application for renewal.

To maintain registration as a catastrophic supplier, the supplier must maintain his or her status as a Board registered rehabilitation supplier by obtaining annual registration renewal.

P. Managed Care Organizations

The Division of Managed Care and Rehabilitation at the Board provides materials to aid in application and certification of Managed Care Organizations. Included in the materials is a comprehensive checklist that should be followed closely by any organization when submitting documentation for application and certification. Organizations should review O.C.G.A. §34-9-208 and Board Rule 208, thoroughly, prior to submitting documents to the Division for consideration of certification.

1. Geographic Service Area (GSA) Coverage for a particular area of Georgia may be provided by individual county or a service area that includes several counties. Except for some counties that have been declared rural, each county requested for certification must have at a minimum, two (2) providers from the 'Medical' category as defined in Rule 208(a)(1)(E)(1). Network listings submitted to the Board for certification should only list the required providers referenced in Rule 208(a)(1)(E)(1)-(10). A map demonstrating coverage area, a grid or matrix demonstrating total number of required providers per county or counties in service area, and an individual provider list that matches the matrix are required documents. All sample contracts between the MCO and providers and facilities that will be used must also be submitted. GSAs may be customized for MCO clients. Customized GSAs must demonstrate sufficient choice for the employee and be approved by the Division of Managed Care and Rehabilitation at the Board prior to implementation.

2. Employee Access to Medical Care Certified MCOs must demonstrate that injured employees will have access to any of the providers listed in Rule 208(a)(1)(E)(1)-(10) for their geographic service area. Restricting the employee to only certain categories of providers is not contemplated by the statute and rule. Employees should be able to look at a network listing to make their choice. In order to access the chosen provider, the employee calls the certified MCO's toll free number listed on the posted WC-P3 panel card. Supervisors or managers may call on behalf of the employee only when the employee is incapacitated or unable to get to a phone. For emergencies, care should immediately be sought from the nearest emergency facility or by calling 911. Employee follow-up with the certified Managed Care Organization is completed as soon as possible. An employee is allowed a one-time change of provider within the network without proceeding through the dispute resolution process by notifying the case manager of his or her new choice of authorized treating physician.

3. Dispute Resolution All certified MCOs must provide a Dispute Resolution Process. The procedure and any forms necessary for Dispute Resolution must be provided to providers, employers and employees prior to the need for Dispute Resolution. Any issues related to the certified MCO's administration, medical treatment, or additional changes of authorized treating physician are appropriate for the dispute resolution process. A peer review group may be utilized to review any medical treatment issues. The certified MCO must complete the dispute resolution process within 30 days of written notice of the dispute. After 30 days, the disputing party may request Board intervention if the issue has not been resolved.

4. Utilization Review Utilization Review for certified MCOs encompasses pre-certification, concurrent, and retrospective reviews of treatment provided to injured employees to determine medical necessity and cost effectiveness. Applying and certified MCOs are referred to O.C.G.A. §34-9-205 and Board Rule 205 regarding the Board's definition of medical necessity. The certified MCO is required to detail, in the application, and to customers of the MCO, how reviews are accomplished and by whom, the time required to process a review, and appeal procedures for reviews. All final decisions are to be in writing to the employee, employer, insurer, authorized treating physician, and any facility involved.

5. Peer Review and Quality Assurance All certified MCOs are to provide a Peer Review system in which an individual provider's practice is compared to the provider's peers or against an acceptable standard. The Peer Review is performed by a majority of providers of the same or similar specialty, and is done as often as is necessary to ensure appropriate delivery of services. Results of the Peer Review are returned to the providers in the network for information and as an informal educational tool. Quality Assurance in certified MCOs is usually represented by a committee of both providers and administrators. The committee reviews the quality of care (results of Peer and Utilization Review) and other services (Case Management and Customer Service) and determines where improvements in the delivery of services can be made. Improvement efforts are documented and reportable to the Board.

6. Educational Materials Certified MCOs must provide information and education on the services they offer insurers/employers. An information card must be given to each employee defining access to medical services when injured. Brochures or handbooks further outlining the procedures and services within the MCO are given to all employees. Network listings of providers in the GSA are made available to the employees. Once the employees have been given information, the employer/insurer may post the WC-P3 panel card notice to employees that they are covered by a Board Certified Managed Care Organization. The date the WC-P3 panel card is posted is the effective date for coverage by the certified MCO.

7. Case Management The medical case manager in a certified MCO acts as a patient advocate for the injured employee while coordinating appropriate medical care and return

to work with the employer of injury. The primary purposes of this medical care coordination are to ensure high quality care, reduce recovery time, and minimize the effects of the injury. The medical case manager updates medical treatment information with all involved parties, facilitating the appropriate return to work of injured employees. The medical case manager assesses cases from the first notice of injury when the injured employee calls the certified MCO's toll free number. After initial contact with the authorized treating physician selected by the injured employee, the medical case manager ensures an understanding among all parties on a treatment plan and time frame appropriate to the diagnosis. There is ongoing assessment of the injured employee's recovery. Treatment and anticipated recovery period are modified as indicated. Case management in a certified MCO is primarily accomplished telephonically with limited use of on-site case management services. MCOs must identify when on-site case management is likely to be utilized. In catastrophic injury cases a registered catastrophic rehabilitation supplier must be assigned.

All case managers in the certified MCO must have at least one year of workers' compensation case management experience. They must have one of the following certifications: Certified Case Manager (CCM), Certified Rehabilitation Registered Nurse (CRRN), Certified Occupational Health Nurse (COHN, COHN-S), Certified Disability Management Specialist (CDMS), Certified Rehabilitation Counselor (CRC), Work Adjustment/Vocational Evaluation Specialist (WAVE), or Licensed Professional Counselor (LPC). Per Rule 208(h)(3) all parties to the claim and their representatives shall cooperate with medical case management services provided by a certified Managed Care Organization who has posted a WC-P3 panel card at an employer's site.

8. Monitoring Records The Board's Division of Managed Care and Rehabilitation shall monitor the records and activities of the certified MCOs. Quarterly reporting of statistics is required. Annual re-certification includes an on-site visit by the Division's Managed Care Coordinator, Board questionnaires to all recipients of the organization's services, and an update from the certified MCO of information on administrative personnel, case managers and provider lists.

9. For further information or to request application materials, please contact the Board's Division of Managed Care and Rehabilitation, 270 Peachtree St., NW, Atlanta, GA 30303-1299, (404) 656-3784.

Appendices to Chapter 7, Procedure Manual

1. Information Required to Process Requests for Catastrophic Designation
2. Flow Chart for Applying to Become a Registered Catastrophic Rehabilitation Supplier
3. Notification of Intent to Apply to Become a Registered Catastrophic Rehabilitation Supplier
4. Catastrophic Supplier Applicant's Proposal Form for Observation/Experience Component
5. Documentation of Completion of Observation/Experience Component by Catastrophic Rehabilitation Supplier Applicant
6. Catastrophic Supplier Applicant's Proposal Form for Training
7. Documentation of Training Attended by Catastrophic Supplier Applicant
8. Housing Checklist – Considerations for Catastrophic Rehabilitation Suppliers
9. Transportation Checklist – Considerations for Everyone Involved

INFORMATION REQUIRED TO PROCESS REQUESTS FOR CATASTROPHIC DESIGNATION:

- Completed Form WC-R1CATEE (current version can be obtained by calling the Board's mailroom at 404-656-3870) with appropriate box checked at top (when requesting a specific rehabilitation supplier, the supplier must be registered with the Board as a catastrophic rehabilitation supplier)

AND

IF FILING IS BASED ON O.C.G.A. §34-9-200.1(G)(1)-(5) (SPECIFIC MEDICAL DIAGNOSES):

- Current medical diagnoses
- Current (within the past year) medical records from the employee's authorized treating physician(s).
- Hospitalization admission and discharge summaries, if available
- For head injuries, a copy of neuropsychological evaluation, if one has been completed
- For multiple digit amputations, diagrams showing sites of amputations
- For burn injuries, percentage of body burned and what type of burns (first, second, third); whether or not five per cent or more of face or hands incurred third degree burns
- For industrial blindness, documentation of employee's current vision

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IF FILING IS BASED ON O.C.G.A. §34-9-200.1(G)(6) (EMPLOYEE IS RECEIVING SSDI AND/OR IS UNABLE TO WORK DUE TO INJURY):

If the employee IS receiving Social Security disability (SSDI) benefits or Supplemental Security Income (SSI) benefits:

- A copy of the Social Security Administration's findings and award of Social Security Disability (SSDI) or Supplemental Security Income (SSI) benefits

OR

- If a judicial decision or rationale was not issued, documentation from the Social Security Administration listing the diagnoses based on which the employee was found to be disabled, as well as notification that he was approved for SSDI or SSI

OR

- If such documentation is unavailable, an affidavit detailing the disability(ies) on which the Social Security award was based, and information about whether or not each of the disabling conditions was related to the employee's work injury

AND ALSO

- The employee's current medical diagnoses (may be included in SSA award)
- Work history for the past 15 years, including physical requirements of each job (may be included in SSA award)
- Education level (may be included in SSA award)
- Current (within the past year and preferably the last six months) opinion from the employee's authorized treating physician(s) regarding whether or not the employee is released to return to work and if so, with what restrictions (may be included in SSA award)
- Information regarding whether or not the Workers' Compensation injury and its residuals were the sole factor or a contributing factor to the disability used as the basis for the Social Security Administration's award of benefits

If the employee IS NOT receiving Social Security disability benefits:

- The employee's current medical diagnoses
- Work history for the past 15 years, including physical requirements of each job
- Education level
- Current (within the past year and preferably the last six months) opinion from the employee's authorized treating physician(s) regarding whether or not the employee is released to return to work and if so, with what restrictions
- Relevant medical records

• FLOW CHART
for
APPLYING TO BECOME A REGISTERED CATASTROPHIC REHABILITATION SUPPLIER

1. Rehabilitation supplier (who must have been a registered rehabilitation supplier for at least two years) sends the form, ***Notification of Intent to Apply for Catastrophic Rehabilitation Supplier Registration,*** to the Board's Managed Care and Rehabilitation Division. Address is Managed Care and Rehabilitation Division; State Board of Workers' Compensation; 270 Peachtree Street; Atlanta, GA. 30303. The form is an appendix to Chapter 7 of the Board's Procedure Manual, and can be obtained by calling the Managed Care and Rehabilitation Division at 404-656-0849.
2. The Board's Managed Care and Rehabilitation Division reviews the ***Notification of Intent*** form. If the supplier is eligible to begin the process of applying to become a registered catastrophic rehabilitation supplier, s/he is sent a list of Rehabilitation Mentors. The applicant is also sent a proposal form (which can be copied) to use to submit proposals for each experience/observation and training component.
3. The applicant contacts a facility, program, or health care professional specializing in one of the disability areas (spinal cord injury, amputation, brain injury, burns, or blindness). The applicant obtains written permission to observe and/or work (paid or volunteer) at that facility or with that health care professional for at least 40 hours in that disability area. The applicant finds a professional at the facility to serve as an on-site supervisor who agrees to document the dates and hours the applicant spends at/with the program. The applicant contacts a Rehabilitation Mentor (from the list provided by the Board's Managed Care and Rehabilitation Division) who agrees to serve as the applicant's Mentor for the experience/observation component.
4. The applicant submits to the Board's Managed Care and Rehabilitation Division a proposal for obtaining the observation/experience component chosen as described in number 3, above. The Catastrophic Certification Committee reviews the proposal, and responds to the applicant within 60 days. The Committee may approve the proposal as written, may approve it with modifications, or may deny it with a written rationale for the denial.
5. Once the proposal is approved, the applicant begins the observation/experience.
6. The applicant documents and has the on-site supervisor sign the documentation of his/her hours of observation/experience.
7. The applicant consults with his/her Rehabilitation Mentor at least once a week, and documents those consultations.
8. The applicant chooses one individual with the chosen disability, and writes an initial rehabilitation report, proposed rehabilitation plan (on Board Form WC-R2A), and narrative justification for the plan, ***as though the individual were an injured employee. No real identification of the person (name, Social Security number) shall be included on the documentation.*** The applicant reviews the proposed documentation with his/her Rehabilitation Mentor.
9. The applicant submits the following required documentation to the Catastrophic Certification Committee by mailing it to the Board's Managed Care and Rehabilitation Division:
    A. Documentation of hours and dates of observation/experience, signed by the on-site supervisor.

B. Written summary of weekly consultations with the applicant's Rehabilitation Mentor.
C. Initial rehabilitation evaluation report, written ***as though*** the individual with the disability being studied were a Workers' Compensation client.
D. Proposed rehabilitation plan for appropriate services for this person, as if the person were a catastrophically injured employee being provided mandatory rehabilitation in the Georgia Workers' Compensation system.
E. Written narrative rationale/progress report justifying the services proposed in the plan.

10. The Committee reviews the documentation outlined above, and will respond to the applicant. If the applicant is required to revise part or all of the submitted documentation, specific information will be provided as to the reasons why. The Committee will review the revised documentation and respond to the applicant.

    The applicant shall repeat the steps noted above (3 through 10) for each of the three disability areas chosen.
11. The applicant shall submit 40 hours of relevant training.
12. When an applicant has successfully completed all of the requirements to become a registered catastrophic rehabilitation supplier, the Board will issue a card documenting the supplier's status as a catastrophic rehabilitation supplier.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

MANAGED CARE & REHABILITATION DIVISION
CATASTROPHIC CERTIFICATION COMMITTEE
270 PEACHTREE STREET, NW
ATLANTA, GA 30303-1299
(404) 656-0849

NOTIFICATION OF INTENT TO APPLY FOR CATASTROPHIC DESIGNATION

Name:_____

Business Address:_____

Telephone:_____ **FAX:**_____

Email Address:_____

Home Address:_____

Georgia Rehabilitation Supplier Registration Number:_____

Are you currently and have you been a registered rehabilitation supplier with the Georgia State Board of Workers' Compensation consecutively for the last twenty-four months? _____

List all certifications you hold, including expiration dates:

By signing this application, I am verifying that I have read and will abide by the Standards of Practice/Code of Ethics of my specific certifications. I understand that it is my responsibility to meet requirements as outlined in the current O.C.G.A. 34-9-200.1, Rule 200.1 and Chapter 7 of the Procedure Manual, which I have read as part of this application. In addition, I realize that changes occur in the rules and the procedures each year and that it is my responsibility to be aware of these changes.

_____ _____

Signature of Applicant **Date**

(Revised 5-09)

Catastrophic Supplier Applicant's Proposal Form
Observation/Experience Component

Applicant must submit a separate proposal for each of the three required disability experiences/observations. Proposals should be submitted prior to completing each component. <u>This form must be legible and complete.</u>

1. **This is my FIRST SECOND FINAL experience/observation *(circle one).***
2. **Applicant's Name:_____Date Submitted:_____**
3. **Address:_____**
4. **Supplier#:_____Fax#:_____Telephone:_____**
5. **E-Mail Address:_____Cell Phone:_____**
6. **Catastrophic Disability to be observed (spinal cord, amputation, brain injury, burns, or blindness):_____**
7. **Site Location or Health Care Professional to be Observed (list name, address, and telephone number):_____**
8. **On Site Supervisor's Name:_____Title:_____**
9. **Catastrophic Rehabilitation Mentor:_____**
10. **Number of years Cat Mentor has been Catastrophic Supplier?_____**
11. **Cat Mentor's Supplier Number:_____Telephone #:_____**
12. **Describe Proposed Experience:-**

_____
_____
_____
_____
_____
_____
_____

Applicant' Signature:_____Date:_____

On Site Supervisor's Signature:_____Date:_____

Catastrophic Mentor's Signature:_____Date:_____

<u>Effective July 1, 2003, the Site Supervisor and the Catastrophic Mentor must be different persons.</u>

Return Completed form to:
State Board of Workers' Compensation
Managed Care & Rehabilitation Division
Catastrophic Certification Committee
270 Peachtree Street
Atlanta, GA 30303-1299
Telephone: (404) 656-0849

Revised 6/03

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

DOCUMENTATON OF COMPLETION OF OBSERVATION/EXPERIENCE COMPONENT OF CATASTROPHIC TRAINING

The required documentation may count for up to 10 of the required 50 hours for each specific disability submitted. If additional space is needed, please attach.

APPLICANT INFORMATION

Applicant Name:_____ **Supplier #**_____

Address:_____

City/State/Zip:_____

Telephone:_____ **Fax:**_____

****

DIRECTIONS FOR COMPLETION

Client Identification: Confidentiality must be maintained: submit only information that clarifies disability (do not use the individual's real name, Social Security number, address or phone number when submitting data requested).

Document information as though the client were an injured worker (as specified in Chapter 7 of the Procedure Manual, Georgia State Board of Workers' Compensation).

****

This documentation is of my (please circle): FIRST SECOND FINAL experience/observation.

The following information must be submitted to document completion of the experience/observation. (All information noted below must be submitted for the experience/observation to count toward the applicant's catastrophic supplier registration application):

- **Log documenting contacts with the Catastrophic Mentor including dates, topic(s) discussed, Mentor's signature and date signed.**
- **Log documenting contacts with on-site supervisors and professionals, listing dates/hours of involvement. Log must show specific activities/observations, and must be signed by the involved professionals.**
- **Submission of an initial rehabilitation report, outlining information as though the observed person were an injured worker.**
- **Submission of WC-R2A(a proposed rehabilitation plan) outlining services as though the observed person were an injured worker.**
- **Narrative report to document proposed plan for the observed person.**

Page Two

CLIENT INFORMATION

THE FOLLOWING INFORMATION MUST BE COMPLETE AND LEGIBLE

Specify diagnosis and related impairment(s):_____

_____

_____

_____

_____

Date of Onset:_____ Current Age:_____ Sex:_____ Rural or Urban:_____

Rehabilitation Mentor:_____Supplier Number:_____

Rehabilitation Mentor's Signature:_____Telephone:_____

Site Location and Address:_____

On-Site Supervisor:_____ Title:_____

On-Site Supervisor's Signature:_____Telephone: _____

1. Current Medical Status:

2. Medical needs and recommendations based on opinions of treating professionals:

3. Current and potential levels of independence (include resources for housing, transportation, mobility, attendant care, community re-entry and recreation):

4. Safety issues and recommendations to implement appropriate safety measures:

5. Social History including assessment of support systems and knowledge of appropriate resource referrals:

6. Prognosis based on assessments of cognitive, behavioral, emotional and physical functioning:

7. Educational background including any schooling or educational courses completed since injury:

8. Employment history including average weekly wage @ time of injury:

9. Current employment status including job analysis, modified work availability, work readiness and restrictions:

10. Vocational/Avocational objectives including justification of recommendations:

11. Other information pertinent to recommendations in WC-R2A:

_____ _____

Signature of Applicant Date

Revised 6/03

CATASTROPHIC SUPPLIER APPLICANT'S
PROPOSAL FORM FOR TRAINING (**)
YOU WILL BE PROMPTLY NOTIFIED OF THE DECISION OF THE CATASTROPHIC CERTIFICATION COMMITTEE

Chapter 2 Date Submitted:_____ Supplier Number:_____

Applicant's Name:_____

Address:_____

_____

Telephone:_____ **Fax:**_____

E-Mail Address:_____

Applicant's Signature:_____

TRAINING PROGRAM

Name of Proposed Training:_____

Location:_____

Address:_____

Telephone:_____

Description of Proposed Training:_____

_____

_____

Hours of Training Proposed:_____

Please include a brochure, if available.

Send completed form to:
State Board of Workers' Compensation
Managed Care & Rehabilitation
Catastrophic Certification Committee
270 Peachtree Street
Atlanta, GA 30303-1299

(**) All training must be pre-approved except the 40-hour courses offered by RWSIR or Shepherd Center.

Documentation of Training Attended
By Catastrophic Supplier Applicant

Submit this form when you have completed at least 40 hours of training related to catastrophic injuries. Do NOT use this form to document the required experience/observation components. If you attended the Roosevelt Warm Springs Institute for Training Catastrophic Internship, attach your completed log, verifying your attendance. No other training is required.

Date Submitted:_____
Supplier Number:_____
Applicant's Name:_____
Address:_____
Telephone:_____
Fax:_____
E-Mail Address:_____

I Certify that I attended the following training on the dates specified. If the training was pre-approved by the Catastrophic Certification Committee, I have noted that in the applicable space:

Training which was pre-approved by the Catastrophic Certification Committee:

Title of Training Date(s) Attended

_____
_____
_____
_____

Training which was NOT pre-approved by the Catastrophic Certification Committee:
Title of Training (With Description and Brochure, if Available) Dates and Hours Attended:

_____
_____
_____
_____
_____
_____

Submit Completed Form to:
State Board of Workers' Compensation
Managed Care & Rehabilitation Division
Catastrophic Certification Committee
270 Peachtree St., NW
Atlanta, GA 30303-1299

HOUSING CHECKLIST – CONSIDERATIONS FOR CATASTROPHIC REHABILITATION SUPPLIERS

The purpose of rehabilitation in Georgia Workers' Compensation is to restore the employee as nearly as possible to his pre-injury situation. The role of the catastrophic rehabilitation supplier is to guide this process.

Although ***payment*** for suitable housing is a claims issue in catastrophic injury cases, ***suitable housing*** itself is a rehabilitation issue. ***Every catastrophic rehabilitation supplier is responsible for researching and coordinating appropriate housing for catastrophically injured employees whose injuries necessitate special housing accommodations.***

Immediately upon assignment to the case, a catastrophic supplier should begin researching housing needs for any catastrophically injured employee who will need modified or wheelchair accessible housing

Always remember that the employee's residence is the center of his life. The employee should be actively involved in making decisions regarding his home. Honor his housing preferences whenever possible.

All phases of the housing process should be covered under specific rehabilitation plans. All plans should designate responsibilities with timeframes. The rehabilitation supplier should share information with all parties as soon as it is obtained.

The following is a checklist to help suppliers ensure that suitable housing is made available to injured workers as expeditiously and effectively as possible.

REHABILITATION SUPPLIER RESPONSIBILITIES FOR ALL CASES:

Ascertain from treating professionals what the employee's current and projected housing needs are and will be.

- The type of injury and its impact on the overall living situation (i.e., individuals with acquired brain injury may need a quiet environment, those with spinal cord injury may need additional space).
- Projected length of stay in the rehabilitation facility or hospital.
- Will permanent suitable housing be available at the time of discharge?
- If not, what arrangements can be made for temporary suitable housing for the employee and family?
- Will the employee be able to live independently?
- What is the family situation?

- Is there a spouse or significant other?
- If so, does the spouse work outside the home?
- Who is responsible for household budgeting?
- Who is responsible for household maintenance and upkeep?
- Will this change post injury?
- Will the employee need training/re-training in these areas?
- Are there children at home and what are their ages?
- Who is the major caretaker for dependent children?
- Do the children share bedrooms?
- Is there any possibility that children may be leaving home?
- How has the employee's injury impacted the family's structure and pre-injury plans and routines?
- What are the family relationships and dynamics?
- Is the marriage stable? .
- Are there other family members living with employee?
- What are the hobbies of the employee and family members?
- Do those hobbies require a special space and/or tools?
- Are there pets at home and are they indoor or outdoor pets?
- Assistance animal for employee?
- Who is responsible for the care of the pets?
- Are there supportive neighbors?
- Other local support systems?
- Will attendant care be prescribed?
- Will it be temporary or permanent?
- How many hours per day?
- Who will provide the attendant care?
- Will there be a live- in attendant?

Visit the employee's current residence as soon as possible after your assignment to the case.

- Does the employee live in a house or apartment?
- Does the employee own or rent?
- Where is the residence?
- Can the employee safely and quickly exit the residence in the event of fire or other emergency?
- Local fire department has jurisdiction and will conduct a free on-site investigation

Determine the employee's pre-injury and current income.

Address potential income sources (e.g. SSDI, DFCS, etc.)

What is the employee currently paying for housing?

- If the employee is a home-owner:
  - What are the yearly taxes?

- What is the average cost of utilities, including telephone?
- Who provides water, sewerage, and garbage collection? What are monthly costs?
- Is there a mortgage? A second mortgage?
- What are the terms of the mortgage(s)?
- How much equity does the employee have in the house?
- Who has title to the house?

- If the employee rents:
  - What is his monthly rent?
  - Is the rental payment current?
  - What are the terms of his lease?
  - What is the average cost of utilities, including telephone?
  - Who provides water, sewerage, and garbage collection? Monthly costs?

GENERAL CONSIDERATIONS

- What is the current medical condition of the employee?
- Can the employee's medical prognosis be predicted at this time?
- Will modifications to the home be temporary or permanent?
- If the employee's condition is progressive, will additional modifications be required in the future?
- Responsibility for present and future maintenance of employee's residence must be decided.
- Will specific accommodations be required for vehicle?
- Kitchen and bathroom accessibility?
  - Does the employee need permanent or temporary modifications?
  - What were the employee's pre-injury hobbies and/or house duties?
  - Will he be able to continue these post injury?
  - Will additional space be needed for storage of supplies and adaptive equipment?
  - Will an exercise room be required?
  - Will/does the employee use a wheelchair and/or scooter? What type(s)?
  - Do these require special space/storage needs?
  - ***Arrange for an occupational or physical therapist to evaluate current residence for feasibility of modification and to recommend appropriate modifications.***
  - What adaptive equipment is also needed?
- The catastrophic rehabilitation supplier shall provide all parties and the Board with drawings and/or photographs clearly outlining room dimensions and appliance and furniture placement in the employee's current residence.
- Coordinate an inspection of electrical and plumbing systems and structural soundness, by a home inspector.
- After review of the home evaluation, discuss with all parties feasibility of modifying current residence.

- Whether the employee remains in his current residence or moves, after the home evaluation, select several experienced contractors to review the home assessment, suggest any additional or alternative modifications, and estimate costs.
    - Check references and credentials to ensure contractor has experience in modification.
    - Work closely with attorneys and case parties to choose the contractor.
    - Have parties agree on at least three contractors if possible, then have employee interview and choose.
    - Are there any judgments or liens pending against the contractor?
    - Contractor is to provide a "lien letter", which shall be specified in contract.
    - Does the contractor hold all required county, state, and city licenses?
    - The contractor should be bonded and insured.
    - Ensure that the contractor obtains all necessary building permits.
    - Identify and agree upon qualified home inspectors (not the rehabilitation supplier) to assess construction quality and quantity prior to each draw after the initial draw.
    - Who will determine and monitor the draw (payment) schedule for the contractor?
        - Who will hold the money?
        - Retention funds should be sufficient to assure contractor's completion of the punch list (contract items not completed at the end of construction) and to pay for any cost overruns (10-20 % reserve for overruns is common)
        - Provision should be made in contract for return of unused funds to payor.
    - Who is responsible for developing and reviewing a contract?
    - How will construction changes be handled?
        - What changes are allowed in contract without price increase?
        - What changes would initiate a price increase?
        - Who will pay for each change?
        - Full set of modified blueprints must be provided to contractor and all subcontractors every time a change is made
        - Who will pay for these extra blueprints?
- ***Resolve all issues of ownership and maintenance prior to any contract or construction.***
- Can the employee safely and quickly exit the residence in the event of fire or other emergency?
    - Some local fire departments will conduct a free on-site inspection.
    - Local government officials and state vocational rehabilitation personnel may also be available to conduct onsite inspections.
- What support services are available in the surrounding community?
- Are they accessible to the employee?

Based on these considerations, the catastrophic rehabilitation supplier shall prepare a cost-benefit analysis of all housing options, and shall provide it to all case parties.

FOR EMPLOYEE WHO WILL REMAIN IN CURRENT RENTAL RESIDENCE

- Discuss with the landlord the possibility of modifications.
  - If landlord agrees to modifications, obtain a written agreement:
    - What the landlord will allow
    - What the landlord is willing to modify.
    - What would have to be restored or removed if the employee moves
    - Obtain the defense attorney's assistance with securing agreement.

- If the employee lives in an apartment
    - Can current apartment be modified to meet post-injury needs?
    - Is the area a safe environment for the employee?
    - Are there any totally accessible units within the complex?
    - If so, is one available now or within a reasonable time period?
    - Does the employee need to move into a larger unit?
    - Is there access to suitable transportation?
    - Are common areas within the complex safe and accessible?

- If the employee lives in a rented house
    - Can it be modified to meet post-injury needs?
        - Are exterior modifications feasible?
        - Is it possible to add an emergency exit from employee's bedroom?
        - Are there paved walkways?
        - Would walkways provide a safe emergency exit route?
        - Is there covered access from automobile or van to home?
    - Is the area a safe environment for the employee?
    - Is there access to suitable transportation?
    - Who is responsible for the interior and exterior maintenance of the house?

FOR THE EMPLOYEE WHO OWNS HIS HOME AND WISHES TO STAY THERE:

- Determine if the title is in the employee's name before modifications are discussed.
- How old is the house?
- Is it feasible to modify based on structural and environmental factors?
    - Are exterior modifications feasible?
    - Is it possible to add an emergency exit from employee's bedroom?
    - Are there paved walkways?
    - Would walkways provide a safe emergency exit route?
    - Is there covered access from automobile or van to home?
    - Is there access to suitable transportation?
- Who is responsible for the interior and exterior maintenance of the house?

FOR THE EMPLOYEE WHO MUST MOVE:

If the current residence cannot be suitably modified or is rented and the landlord will not allow modifications, research all possible alternatives:

- Renting an accessible residence (apartment or house) (see next section),
- Buying a house which could be suitably modified (consider the assistance of a realtor who is familiar with modified housing),
- Building a house.
- Include all costs and other factors for each option:
    - Land/lot
    - Topography surrounding the property
    - Utilities, sewerage and water
    - Feasibility of each option
    - Factors affecting medical treatment (e.g. access to suitable transportation, hospitals, doctors, emergency treatment, pharmacies, etc.).
    - Factors influencing potential employment
    - Transportation options

If the employee is currently renting, research any possible rental houses or apartments which may be appropriate and visit them in person.

- Obtain all costs and conditions:
- Monthly rental fee and what it includes
- Lease requirements
- Who will sign rental/lease agreement?
- Employee's credit history?
- What utilities included in rent?
- Cost of utilities not included in rent?
- Laundry area – are there washer dryer connections in the residence and if so, are they accessible to the employee?
- Recreational facilities?
- Parking facilities and accessibility
- How many occupants are allowed in a rental unit?
- If landlord agrees to modifications, obtain a written agreement specifying the following:
    - What the landlord will allow
    - What the landlord is willing to modify.
    - What would have to be restored or removed if the employee moves
- Obtain the defense attorney's assistance with securing agreement.

If the employee now owns his home, but it cannot be made suitably accessible, and a decision has been made to buy or build an accessible home

- What equity does the employee have in the house?
- Will he be required to sell the house and apply the proceeds to a new, accessible house?
- How much will the insurer contribute to the cost of the new house?
- Who will hold title to the house?
- Who will be responsible for completing a title search?
- What happens if the employee moves? (This and other issues may be covered in a one-time partial stipulation for housing.)
- What provisions will be made if the employee moves into a nursing or personal care home?
- What will happen if the employee dies?

Develop a written cost comparison of the employee's pre-injury living situation, income, and housing costs versus his current financial situation.

- Is the employee's financial situation likely to change?
- Discuss with the employee and all other case parties all possible alternatives and their costs and feasibility.
- Write a comprehensive report outlining your research findings.
- If possible, negotiate a housing agreement with all parties.
- Even if parties cannot agree, develop a specific rehabilitation plan proposing the options that are most suitable, feasible and cost effective based on your research.
- **Do not wait for parties to agree.**
  - If a party objects to the plan, the State Board's Rehabilitation Coordinator will hold a conference with all parties to resolve the issue by agreement or administrative decision.
  - The catastrophic rehabilitation supplier's promptness in researching options and developing and distributing a proposed housing plan can eliminate months and years of delay for injured workers.

Once a decision is made regarding where employee and family will live, spell out in rehabilitation plans all related decisions:

- What type of housing has been selected?
- Is residence large enough to accommodate special equipment and supplies and turning radius of employee's wheelchair?
- If there is a lease, who will sign it?
- Who will have responsibility for monthly house or rental payments?
- Who will be responsible for deposits (if required) or down payment?
- Who will be responsible for moving expenses?
- Who will pay for utilities and phone?

- If a new home is the option selected, whether purchased or built, address the following:

- Have attorneys and/or realtor review with employee the mortgage(s) on the existing dwelling (rehabilitation suppliers shall not explain terms of financial agreements).
- How much equity is available and who will make the down payment on the new house?
- Will the employee's old house be sold or leased?
- If to be sold, have parties agree on at least three realtors, then have employee interview and choose.
- How will new dwelling be handled while home is being sold?
- ***Again, all of these provisions are to be spelled out in a rehabilitation plan with time frames.***
- If the new home is titled in the employee's name, who will pay taxes and insurance?
- Who will retain ownership of the home?
- If a pre-existing house is bought –
- Refer to General Considerations
  - Who will provide modifications?
  - Is there a written plan?
  - Periodic inspections should be arranged
  - Who will complete them, on what schedule?
  - Who will provide the final inspection prior to the final draw? The inspection must assure that all of the building and modifications meet state, local, and city codes.
- Certificate of occupancy must be provided prior to employee's moving in to new residence

- **Note:** Even if parties agree to a one-time stipulation to settle housing for the life of the claim, housing needs must still be addressed in rehabilitation plans.

Payment issues should be addressed in rehabilitation plans: who pays for what, and when? (The case parties noted in parentheses should be consulted for the issues noted; the employee should always be involved.)

- If the employee's old home is to be sold and/or a new home bought, determine if a realtor is needed. (Rehabilitation supplier, claims representative, plaintiff attorney)
- Consult attorneys to assure that sales/contracts/documents are legal.
- Who will pay for the employee's move? (Claims representative, employee, attorneys, rehabilitation supplier)
- How will the employee move? (Rehabilitation supplier, employee and claims representative)
- Insurance (Rehabilitation supplier, employee and defense attorney)
- House inspection if new construction or if buying pre-existing house (Rehabilitation supplier, employee, occupational therapist and defense attorney with realtor if appropriate)
- Taxes (Rehabilitation supplier, employee, claims representative and defense attorney)
- Termite letter (Rehabilitation supplier, employee, defense attorney and realtor if appropriate)

- Rehabilitation supplier should ensure that the defense attorney completes a title search.
- Valid sales contract completed with the cooperation of all parties. (Defense and plaintiff attorney)
- Down payment (Rehabilitation supplier, employee, both plaintiff and defense attorneys and claims representative)
- Mortgage payments – will taxes and insurance be escrowed or will they be paid separately (Rehabilitation supplier, employee, plaintiff and defense attorneys)?
- In whose name is title for the residence? (Rehabilitation supplier, employee, claims representative, plaintiff and defense attorneys)
- What happens if employee dies? (Employee, claims representative, plaintiff attorney, defense attorney and rehabilitation supplier)
- Maintenance of house and yard (how frequently and specifically what) (Rehabilitation supplier, employee, claims representative, plaintiff attorney and defense attorney)
- If new construction, what is the draw schedule and who is responsible for holding building funds during construction? (Claims representative, employee, rehabilitation supplier, plaintiff attorney and defense attorney)
- If renting, who pays for the rent or any portion of it, how often, when? (Claims representative, employee, attorneys)
- Who pays for utilities, including basic telephone and long-distance charges? (Claims representative, employee, attorneys, rehabilitation supplier)
- What emergency system will be used? (Rehabilitation supplier, employee, claims representative, plaintiff and defense attorneys.)
- How often are utility services compromised in the area and what is the impact of this? (Rehabilitation supplier)
- Are the driveway and road accessible to emergency vehicles? (Rehabilitation supplier)
- Is there plan for a back up generator if one is needed? (Rehabilitation supplier, employee, claims representative, plaintiff and defense attorneys)
- Responsibility for contacting electric and gas companies, telephone company, fire and police departments for emergency purposes. (Rehabilitation supplier)
- If transportation will be needed to medical, rehabilitation, and recreational appointments and events, is it available in the neighborhood of the chosen residence? (Rehabilitation supplier, employee)
- Resolution of long-term maintenance issues (attorneys, employee, claims representative, rehabilitation supplier)

Always remember that you are the advocate for the injured worker. A catastrophic injury causes major change in lifestyle, daily routine, home life, and employment. The employee must retain as much control over his life as possible. Your role is to assist the employee in the critical decision-making process regarding his home. It is your responsibility to advocate for the employee by assisting the claims representative and all case parties in understanding how your recommendations are both best for the employee and the most cost effective for the carrier.

Housing Resource Information is available for review at the Managed Care & Rehabilitation Division of the State Board of Workers' Compensation. Call 404-656-3784 to make an appointment to review this information on site.

TRANSPORTATION CHECKLIST

I. PURPOSE OF PAPER

The purpose of this paper is to help clarify the various transportation issues, which exist in catastrophic and non-catastrophic workers' compensation situations. The primary guideline for determining transportation is based on Georgia State Board of Compensation Rule 200.1, which states the understanding that the goal of Rehabilitation Services is to "*provide items and services that are reasonable and necessary for catastrophically injured employees to return to the least restrictive lifestyle possible.*" All parties are charged with the fulfillment of this goal.

II. TRANSPORTATION

A. General Considerations

The Rehabilitation Supplier needs to identify transportation needs of the injured worker, taking into consideration appropriate options as discussed in this paper.

An injured worker who experiences cognitive and/or physical injuries which impact his ability to drive, will need to be involved in appropriate evaluations to determine cognitive and physical abilities, before being cleared to resume driving and to determine transportation needs. It is preferable for the injured worker to maintain driving independence. However, their previous driving record/history may impact decisions regarding transportation. Driving potential often cannot be determined right after initial injury, due to other medical complications or factors.

Research all positive/negative factors for providing what is medically necessary, as well as appropriate, for the individual's specific needs. Consider safety, reliability, extent of transportation needs, location of individual geographically, resources in the area and costs of each choice, short term and long term.

B. Rehabilitation Supplier Responsibilities

1. Identify transportation needs of the injured worker for

a. Medical and rehabilitation appointments

b. Personal business

c. Social/ recreational/health maintenance

d. Pre-vocational and vocational activities

e. Avocational activities

2. Assess the need for an evaluation of the injured worker's physical and/or cognitive abilities as related to driving

a. Physical functions affecting driving ability may include, but are not limited to: range of motion, muscle strength, reaction time, mobility status, transfer ability, sensation and visual skills. These may be associated with conditions such as, but are not limited to: Amputation, Neuropathy, Spinal Cord Injury, Complex Regional Pain Syndrome, Visual Impairments and Extremity Impairments.

Additional visual testing may be necessary to identify visual deficits that may affect driving.

b. Cognitive functions affecting driving ability may include, but are not limited to: processing speed, concentration, attention span, reaction time, visuospatial judgment and ability to generalize. These may be associated with conditions such as, but not limited to: Brain Injury, Stroke, psychological factors and medication issues as determined by the treating physician.

In brain injury/stroke cases, a neuropsychological evaluation will address deficits accurately and give data to help determine ability to drive, make judgments, learn new skills, etc.

The Rehabilitation Supplier must be aware that cognitive functioning is an ongoing, dynamic process, affected by aging, functional changes and technological advances.

3. Coordinate a driving evaluation with Certified Driver Rehabilitation Specialist (www.aded.org) (see section "C" for information re: driving evaluations)

4. Assess and recommend transportation options - consider short-term vs. long term intervention. Injured worker considerations include: age, conditioning, strength, weight, disease progression and overall medical status. Vendor considerations include knowledge, experience, reliability, availability for service and geographic location in relation to the client.

Using adaptive equipment modifiers registered with the National Highway Traffic Safety Administration (NHTSA) is recommended to ensure that Federal Motor Vehicle Safety Standards are met. (www.nhtsa.dot.gov/cars/rules/adaptive/Modifier/Index.csm)

a. Contract taxi or medical transport

1) Type of transportation (ambulance, medical transport, auto) should be

based on the injured worker's mobility needs; i.e. ambulatory or dependence on mobility devices.

2) Dependability of service, cost, availability in area needed, etc. should be a consideration on an individual basis

3) Injured worker's level of confidence, competence and safety issues need to be relayed to the transportation company

b. Public transit

1) May offer an alternative source for specific appointments an personal activities

2) Must consider convenience (travel time, route changes, stops in relation to destination), availability (route schedule), accessibility (does injured worker have mobility/cognitive skills to use system), and safety issues.

c. Rental

1) Rental of handicapped, accessible vans for short-term transportation may be financially appropriate

2) Some minimal adaptive equipment, such as hand controls, may be available through car rental agencies. Use of this type of equipment is not recommended prior to the injured worker receiving a driver's evaluation.

3) Must consider who is to hold the vehicle insurance on the rented unit

d. Modification of vehicle

1) Should be based on a dependent passenger or driving evaluation, type of mobility device and/or prescribed vehicle equipment needs

2) Assess and determine cost effectiveness to modify employee's existing vehicle, considering the age of the vehicle, mileage and operating condition. A mechanical diagnostic evaluation may be necessary to determine condition of vehicle and projected life expectancy of vehicle. It is recommended to use an ASE Certified mechanic. In addition, it must be determined that any existing vehicle can be modified safely and within the context of Federal Motor Vehicle Safety Standards.

3) Average replacement schedule for a new vehicle is approximately 7 – 10 years, depending on mileage and condition of vehicle.

4) Adaptive Equipment ranges from spinner knobs and left footed accelerators to high tech hand controls and computerized joystick systems. Adaptive equipment training may require 5 to 40 additional hours. In special circumstances, this could be higher.

5) Rarely are structural modifications (raised roof, lowered floor) performed on older vans. Additional weight could cause accelerated wear and tear and may be dangerous. Some equipment such as hand controls and foot pedals may be moved to another vehicle. Consider cost to move equipment from one vehicle to another.

6) Financial considerations (see section J)

e. Auto vs. van vs. truck (See section D)

5. Educate all parties (claimant, adjuster, attorneys, etc.) concerning recommendations to be made in the rehabilitation plan. This can include options, costs analysis and medical necessity.

6. Develop and submit proposed Independent Living Rehabilitation Plan (per Rule 200.1 (a) (5) (ii)) incorporating proposed transportation needs. This must be substantiated by documentation, including, but not limited to: driving evaluation, functional evaluations, seating/mobility evaluations, cost projections and physician orders.

a. A plan should always be in place that allows the injured worker to be transported safely as a passenger, even if he is the primary driver.

1) A secure lock down should be in place for the wheelchair, even if unoccupied.

2) An able bodied driver should be able to operate the vehicle, if necessary

3) If the injured worker's vehicle is not modified so that he/she can be transported as a passenger, an alternative transportation service needs to be provided.

4) Likewise, if the modified vehicle is inoperable, alternative transportation needs to be provided.

C. **Driving Evaluation**

1. General Considerations

A driving evaluation will assess physical, visual, perceptual and cognitive skills, as well as identifying safe/unsafe-driving techniques. It will also help identify adaptive equipment needs. Referral for a driving evaluation with a

Certified Driver Rehabilitation Specialist (CDRS) is strongly recommended and should be performed by a provider that has both clinical and on-the-road evaluation capabilities available. Specific adaptive equipment should be listed as a result of the evaluation, in order to obtain physician orders and clear and cost effective bids as needed.

a. According to Georgia Law (Code Section 40-5-35) a driver must be seizure free for 6 months.

b. A driver's license or learner's permit is required unless otherwise specified by the Certified Driver Rehabilitation Specialist (CDRS)

c. Both a car and a van may need to be available for assessment. The injured worker should test all equipment being recommended during the "on the road" evaluation

d. The optimal time for referral varies based on physical recovery, ability to learn new tasks/techniques, and the effect of medications on the central nervous system and cognitive function.

e. Information needed includes physician prescription and a brief medical summary (current report addressing functional abilities impacted by disability and medications).

f. If the injured worker does not pass the evaluation, re-evaluation in 6-12 months may be an option. A driver's training/rehabilitation program may assist the injured worker in passing the evaluation.

2. Specific Considerations

a. Physical

If the injured worker uses a mobility device (power or manual wheelchair, scooter) or functional/adaptive aids, this equipment needs to be available for the driving evaluation.

b. Cognitive

A driver's evaluation may not be appropriate for 3-9 months post injury, unless it was a light stroke or minor head/brain injury with few residual deficits. Consult the treating physician regarding the timing of this evaluation.

C. **Vehicle Types/Equipment Needs**

The injured worker's capability to transfer himself/herself, with or without assistance, and ability to load/unload his/her mobility device, must be considered in all aspects of vehicle purchase and modifications (See Decision Tree).

1. Automobile

Automotive design recommendations will depend upon the physical size and limitations of the injured worker, type and size of mobility device to be utilized and the need for accommodation in driving controls to safely drive vehicle. Many of these questions will likely be addressed as part of the driving evaluation.

The injured worker should test his/her ability to load and unload the mobility device into the automobile being considered for purchase.

a. Accommodations may include accelerator and/or brake modifications, hand controls and a power driver's seat. Consideration should be given to automatic windows, door locks and side mirrors.

b. Assess need for two-door or four-door design to facilitate loading/unloading of mobility device.

c. Seat height should accommodate both transfers and visibility.

d. Distance between the steering wheel and injured worker must allow for transfer of mobility device into vehicle. This may require a powered driver's seat.

e. A bench seat may be more practical than bucket seat for making transfers

f. Assess the vehicle's capability to bear the weight of adding a loader type lift.

g. If transfers, loading/unloading and vehicle operation requires significant expenditure of energy from the injured worker, the appropriateness of an automobile versus a van should be reassessed. Future and premature damage to the injured worker's upper extremities should be considered.

2. Truck

If a truck is utilized, the structure, height of truck, need for extended cab (particularly for a lift) and a canopy to the truck bed need to be addressed. Lifts are available for putting a wheelchair/scooter into the bed of a truck and also for positioning the injured worker into the driver's seat.

3. Mini-Van versus Full Size Van

Structure, weight, tonnage, lift platform options, size of engine, wheelbase, lowered floor and/or raised roof, terrain, individual level of function and technology requirements are all factors that determine appropriate van purchase.

a. A van has to be large enough to provide easy ingress and egress, as well as maneuverability of interior space.

b. Family size, cargo capacity, vehicle handling, visibility, fuel economy, maintenance costs, tire replacement, ground clearance and garage access are considerations for any van.

c. Full size vans, such as the Ford E-250 may be preferred due to the higher gross vehicle weight rating, heavy-duty systems, and overall durability. With modifications, this vehicle can accommodate clear unobstructed entry for individuals with a seated height of up to 60 inches or more. Recommendations for lowered floors and raised roofs should be obtained through a driver's evaluation

E. **Handicapped Permit and License Plate**

The treating physician will determine whether the injured worker will qualify for a handicapped permit/plate. In the case of a long-term disability, an injured worker has the choice of either a portable handicapped permit or a handicapped license plate. Temporary permits are available for short-term use.

1. Handicapped Permit form is obtained from the local State Driver's License Office and must be completed by the treating physician. Some physicians have this form in their offices. The permit form must be notarized. The permit is portable and can be used in any vehicle in which the injured worker travels.

2. Handicapped license plates are obtained from the local county tag office. The physician must complete the handicapped permit form and it must be notarized. Fees for this license plate are the same as a regular plate. To obtain a handicapped license plate, the disabled person must have the vehicle title in his/her name. This license plate is not portable or transferable.

F. **Outside Carriers, Lifts and Ramps**

Safety, security, exposure to weather, handling and maneuverability of the vehicle, possible damage to mobility equipment, cargo space, injured worker's functioning level, vehicle modifications and cost are all factors to consider in determining the appropriate system.

1. External lifts/trailers

The vehicle must be retrofitted with an approved hitch and platform. The size of engine and type of vehicle determines if this type carrier can be considered. The

wheelchair/scooter is transported outside of the vehicle. This system allows for easy access to equipment and no cargo space is required.

The injured worker must be able to position and lock down the scooter/wheelchair and be able to ambulate from the back of the vehicle, if no one is available to assist.

2. Inside lift

An inside system allows the injured worker to transport mobility equipment inside the vehicle.

a. An unoccupied hoist lift positions the wheelchair/scooter into the bed of a truck or through the rear door of the vehicle. The injured worker must be able to attach the wheelchair/scooter to the lift and be able to ambulate to get into the vehicle, if no one is available to assist.

b. Fully automated lifts allow the injured worker to be lifted inside the vehicle while occupying his/her mobility device and can be operated independently or with assistance. The type of lift is determined by total combined weight of the injured worker and the mobility device. This information should be provided through the driving or dependent passenger evaluation.

3. Ramps

Generally, ramps are used on mini vans only, due to the safety concerns and degree of incline.

a. Automated Ramp

Allows injured worker to ingress/egress (enter/exit) while occupying a mobility device and can be operated independently or with assistance.

b. Manual Ramp

Manual ramps are available for occupied mobility devices if attached to a vehicle, assuming the ramp angle is safe and that the mobility device has adequate traction and power. Manual ramps require assistance.

G. **Portable Ramps**

Portable ramps are available for wheelchair /scooter users to carry in their vehicles to allow access to areas not handicapped accessible. These ramps are lightweight and available in varying lengths.

H. **Home Ramp System**

Refer to the housing paper regarding ramp specifications for covered areas.

I. **Accessible Covered Areas**

Mobility problems may restrict the speed at which an injured worker may *enter* (ingress) and *exit* (egress) from a vehicle. Exposure to the elements may be particularly hazardous to an injured worker's health and the preservation of the mobility device. In such cases, the Board will require a covered parking area. For example, people with spinal cord injuries have a hard time regulating their body temperature, so exposure to rain/cold, etc., could have medical consequences.

Where feasible, it is preferred that the covered parking area be attached to the home. Parking requirements will vary on a case-by-case basis. The parties should take a common sense approach as to what each injured worker will need, based upon his/her individual factors.

J. **Financial Considerations**

1. Consider purchase versus rental, pre and post injury insurance rates, and maintenance costs for vehicle. Case parties need to determine, prior to the actual purchase and modifications, their financial responsibility in the transportation process and who is paying for what. This must be documented in an Independent Living Rehabilitation Plan.

2. Traditionally, vehicles are considered an ongoing rehabilitation expense due to scheduled replacement of vehicle and ongoing maintenance and repairs related to prescribed adaptive equipment.

3. If a vehicle is purchased or modified and that vehicle is utilized in rehabilitation services, (such as medical appointments, pharmacy, rehabilitation/vocational services, etc), the injured worker is reimbursed for mileage, per the Georgia Worker's Compensation Fee Schedule, unless negotiated otherwise. This reimbursement compensates for gasoline and wear and tear on the vehicle.

4. Maintenance costs to the prescribed adaptive equipment is the responsibility of the employer/insurer.

5. Extended Warranties on the entire vehicle are strongly recommended to protect all parties, increasing the life of the vehicle and adaptive equipment and reducing replacement time.

6. General maintenance for the vehicle remains the responsibility of the injured worker, unless negotiated otherwise.

7. Insurance: generally, the injured worker is responsible for continuing payments of the vehicle insurance premiums, based on pre-injury vehicle insurance costs. The employer/insurer is responsible for additional insurance premium costs due to the increased value of the vehicle and modifications required, unless negotiated otherwise.

8. Cell phone service, as medically prescribed, is essential for persons with the potential to develop a medical or vehicle emergency while driving independently or being transported.

9. The injured worker is responsible for maintaining current tags/ad valorem tax, based on pre-injury vehicle costs, with the employer/insurer being responsible for additional cost due to increased value of the vehicle and modifications, unless negotiated otherwise.

10. Title determination must be addressed by case parties on an individual case basis. To obtain a Handicapped License Plate, the disabled person must have the vehicle title in his/her name.

K. **Ethical Considerations**

The concept of "normalization" is especially vital to individuals who require adaptive equipment for independent functions. Access to the community is an important aspect of normalization. Rehabilitation Suppliers have an ethical obligation in working with the catastrophically injured worker to ensure that transportation is available, not only for medical appointments and independent living activities, i.e.: shopping, but also for recreational activities.

The Rehabilitation Supplier has a vital role in the process of obtaining appropriate transportation, taking into consideration the injured worker's preferences and the cost effectiveness for the insurer. Each injured worker has individual physical needs and life-style requirements. The independence offered by the appropriate vehicle and mobility equipment can be life changing.

L. **Disclaimer**

This transportation information is being provided as general information and to assist with giving appropriate solutions for various transportation issues that may arise while working with an injured worker during the rehabilitation process. It is not all-inclusive or specific to an individual injured worker's needs. It is to be used as a guide to explore transportation issues with all parties.

The Board's Managed Care and Rehabilitation Division wish to thank the following people for their valuable input and research in developing this document:

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ATTACHMENT TO TRANSPORTATION CHECKLIST

DECISION TREE
Car versus van

Can the person transfer independently and efficiently to a car? (If it takes too long or takes too much energy, it might not be worth the effort)

a. No Consider a van with a person driving from a wheelchair or transfer seat. Skip to #5
b. Yes Car is a possibility. (If the person owns a vehicle that is not a car, such as a pickup truck, SUV or van, make sure they can transfer into their personal vehicle, not just vehicle) Proceed to next question.

Does the person have a mobility device? (walker, crutches, canes, wheelchair, scooter)

No Car should be possible
Yes Proceed to next question

Can the person load and unload their mobility device independently?

No Proceed to next question.
Yes Car should be possible (If the person owns a vehicle that is not a car, such as a pick up, SUV or van, make sure they can load this device into their personal vehicle, not just any vehicle)

Can the person load and unload their mobility device using adaptive equipment such as a lift or topper? (NOT compatible with all wheelchairs and scooters or with all vehicles)

No Van should be considered
Yes Car can be considered.

Can the person transfer efficiently to a level or downhill surface?

No Consider a van for a wheelchair driver with a lowered floor in cargo and driver's areas and an automatic lockdown.
Yes Consider a van with a transfer seat. This may allow the person to avoid some structural modifications. (Keep in mind they may have to reposition their legs several times while moving into position under the wheel. Tall people or people with bad extensor spasms can have problems with the narrow space between seats)

Is their seated height more than 5'3'? (applies to dependent passengers also)

No Consider flat top or lowered floor minivan.
Yes Consider raised roof and doors.

Is their seated height more than 5'5"? (applies to dependent passengers also)

No Can consider either lowered floor minivan or full size van. See next question.
Yes Should only consider full size van.

Can the person push or drive up a minivan ramp

No Should only consider full size van

Yes Can consider either lowered floor minivan or full size van

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Chapter 8

GEORGIA SUBSEQUENT INJURY TRUST FUND

A. Legislative Intent

Effective July 1, 1977 the Georgia Legislature amended the Georgia Workers' Compensation Law by creating a Subsequent Injury Trust Fund and enacted the following statement of legislative intent:

> "It is the purpose of this chapter to encourage the employment of persons with disabilities by protecting employers from excess liability for compensation when an injury to a disabled worker merges with a pre-existing permanent impairment to cause a greater disability than would have resulted from the subsequent injury alone."

B. Administration of the Fund

The Subsequent Injury Trust Fund was established as a separate agency independent from any other department. The Fund is governed by a five-member Board of trustees appointed by the Governor for six-year terms. Board members represent management, labor, the insurance industry, rehabilitation professionals, and the public at large. In addition, ex-officio or advisory members are the Executive Director of the State Board of Workers' Compensation and the Georgia Insurance Commissioner. The Board of trustees appoints an administrator who is responsible for the day-to-day management and the administration of the fund.

C. Prerequisites for Reimbursement from the Fund

The employee must have a pre-existing permanent impairment.

The law defines “permanent impairment” as any permanent condition due to previous injury, disease or disorder, which is, or is likely to be, a hindrance or obstacle to employment or re-employment. In addition, the employer must have reached an informed conclusion prior to the occurrence of the new injury or occupational disease that the pre-existing impairment was permanent and likely to be a hindrance to employment or re-employment.

There must be a merger between the pre-existing impairment and the new injury. Merger is defined as follows:

1. Had the pre-existing permanent impairment not been present, the subsequent injury would not have occurred. (Example: A blind worker does not see a dangerous situation developing and consequently suffers injury by accident.)

2. The disability resulting from a new injury in conjunction with a pre-existing, permanent impairment is substantially greater than that which would have resulted had the pre-existing, permanent impairment not been present and the employer has been required to pay and has paid compensation for that greater disability. (Example: An employee with a pre-existing heart condition who suffers a compensable heart attack because of aggravation of the pre-existing heart condition.)

3. Death would not have been accelerated had the pre-existing, permanent impairment not been present.

D. Conditions Covered

As stated in paragraph C, a permanent impairment is any permanent condition due to a previous injury, disease, or disorder which is likely to be a hindrance or obstacle to employment. Furthermore, the law requires that the employer reach an informed conclusion that it considered the impairment permanent and likely to be a hindrance to employment. When the employer established knowledge (prior to the subsequent injury date) of any of the following conditions, there is a presumption by law that the employer considered the condition to be permanent and likely to be a hindrance to employment or re-employment:

1. Epilepsy

2. Diabetes

3. Arthritis which is an obstacle or hindrance to employment or re-employment

4. Amputated foot, leg, arm or hand

5. Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally

6. Cerebral palsy

7. Residual disability from poliomyelitis

8. Multiple sclerosis

9. Parkinson's disease

10. Cardiovascular disorders

11. Tuberculosis

12. Mental retardation provided the employee's intelligence quotient is such that he falls within the lowest two percentile of the general population. It shall not be necessary for the employer to know the employee's actual relative ranking in relation to the intelligence quotient of the general population

13. Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months

14. Hemophilia

15. Sickle cell anemia

16. Chronic osteomyelitis

17. Ankylosis of major weight bearing joints

18. Hyperinsulism

19. Muscular dystrophy

20. Total occupational loss of hearing as defined in Code Section 34-9-264

21. Compressed air sequelae

22. Ruptured intervertebral disc

23. Any permanent condition which, prior to the injury, constitutes a 20 percent impairment of a foot, leg, hand, or arm, or to the body as a whole

One of the questions most frequently asked by employers and insurers alike is: "What must an employer do to establish that it reached an informed conclusion that it considered the prior impairment likely to be a hindrance to employment?" There is obviously no one answer to this question because each employer looks at this situation differently. The following represents the fund's position: The employer must provide factual information verifying knowledge and supporting the conclusions that the pre-existing condition was permanent and a hindrance to employment. Several items may be available in a case to help establish the above. These are:

1. What the employee says;

2. Visible impairment (i.e. obvious impairment, a physical condition readily visible to the employer);

3. Job modifications;

4. What fellow employees say to employer;

5. Medical reports;

6. Employment applications;

7. Post offer-employment physical evaluations, questionnaires (if the employer is subject to the ADA);

8. Prior group insurance claim;

9. Prior workers' compensation claims;

The above represents several elements of factual information, which may support the employer's informed conclusion. It must be emphasized that the employer's knowledge and informed conclusion must take place prior to the subsequent injury, not necessarily prior to the date of hire or offer of employment. The insurer or physician's knowledge in absence of employer's knowledge is not sufficient.

NOTE: Submission of an employee's confidentially held medical records in employer's files to Industrial Commissions and Second (Subsequent) Injury Funds is authorized per the EEOC's assistance manual on the Americans with Disabilities Act.

E. Knowledge Affidavit

The employer is required to submit a notarized knowledge affidavit containing the information outlined in the example found in Rule 622-1-.05. The Subsequent Injury Trust Fund will supply knowledge affidavit forms to the employer or insurer upon request, free of charge. This form may also be downloaded from the fund's website www.ganet.org/sitf/. Submission of the knowledge affidavit to the fund is a prerequisite; however, this does not automatically entitle the employer or insurer to reimbursement. If the fund has any questions regarding the validity of information contained in the knowledge statement, the fund will either contact the employer or insurer for additional clarification or conduct an investigation on its own.

On many occasions, employer's knowledge affidavits are not consistent with other facts in the case. The claims person should review the employer's knowledge statement in light of other facts in the case as they pertain to the employee's prior impairment and injury.

Often the employer will refer to source documents such as employment applications, medical reports, pre-employment or post-employment offer reports and others as sources

of information about the prior impairment. When this occurs, the employer must submit a copy of the referenced documents and certify that they were contained in the employer's files prior to the subsequent injury date. The fund's objective is to receive an affidavit from the employer that basically stands on its own merits.

Code Section 34-9-361 requires that the employer establish that it reached an informed conclusion that it considered the prior condition permanent and a hindrance to employment. The employer must reflect those facts or circumstances known to the employer that aided it in establishing the "informed conclusion" required under the law. The affidavit contents outline those circumstances.

Frequently, investigations reveal that the employer knows very little about the contents of the affidavit. Some employers have even indicated that the affidavit was pre-prepared with little or no discussion and submitted for signature. When this occurs, the chances of the fund denying the claim are greater. As a legal document the importance of the affidavit should be discussed with the employer. One should emphasize that the employer relay its true understanding and feelings about the employee's prior impairment. The affidavit should be prepared and signed by someone who is in a responsible position involved in the employment or employee retention process.

F. Filing of Claims

The law requires an employer or insurer to notify the administrator of the fund of any possible claim against the fund as soon as practicable, but in no event later than the payment of 78 weeks of income or death benefits, or within 78 calendar weeks from the date of injury, whichever occurs last. In addition, the employer's claim must be filed with the fund prior to the employee's final settlement of his/her claim.

The payment of 78 weeks of income or death benefits does not necessarily constitute a calendar period; 78 weeks of benefits could be paid over a longer period, or in a lump sum.

It should be stressed that the employer or insurer file its claim as soon as practicable and no later than the statutory requirement.

The employer/insurer must file the initial claim with the fund. Notification shall be in writing, transmitted on the facsimile machine, or transmitted electronically via the fund's website www.ganet.org/sitf/ and shall be effective on the date of receipt of the notice by the fund. The notification must be filed on the Subsequent Injury Trust Fund's Form "A", which is referred to as Notice of Claim. In addition, the employer must provide the following information:

1. Employer's knowledge affidavit pursuant to Rule 622-1-.05 of the Subsequent Injury Trust Fund.

2. Documentation supporting merger between the subsequent injury and prior impairment. This is usually medical information or sufficient investigative materials to support merger dependent upon the type of merger claimed by the employer or insurer.

3. Proof of a compensable injury under Georgia Workers' Compensation laws.

4. When an employer's claim has been accepted for reimbursement, proof of payment of weekly income benefits to the injured worker in excess of 104 weeks or payments for medical and rehabilitation benefits in excess of $5,000.00 or proof that an award of such benefits has been issued.

The Subsequent Injury Trust Fund will supply upon request the forms necessary to complete the above at no charge to the employer or insurer, or they can be downloaded from the fund's website www.ganet.org/sitf/.

The documentation referred to in the above statements is generally developed in a manner concurrent with the development of the employer or insurer's file. The fund reviews each active claim and will request additional information, if necessary.

An employer should look for certain elements that will be helpful in determining when it should file a claim against the fund. Medical reports often reveal the existence of prior impairments or aggravations of pre-existing conditions by the subsequent injuries.

When the reserves of a case approach 104 weeks or $5,000 in medical expense, a claim should be filed. If a lump sum payment of 78 or more weeks or medical expense in excess of $5,000 is anticipated, one should file before making such a payment.

G. Expenses Covered

When a case qualifies for reimbursement from the fund, the employer is at all times required to pay all compensation benefits directly to the injured worker. If payment exceeds 104 weeks of income benefits, the fund will reimburse 100% of all income payments thereafter.

The employer is responsible for the first $5,000 in medical care and rehabilitation services. The fund will reimburse 50% of all medical and rehabilitation expenses, which exceed $5,000 but do not exceed $10,000. After medical and rehabilitation expenses exceed $10,000 the fund will reimburse 100% of all medical and rehabilitation expenses. Reimbursement requests should be made as soon as the employer or insurer has received the Workers' Compensation Board approved Reimbursement Agreement, and every 13 weeks thereafter. Reimbursement checks are usually issued bi-monthly.

Medical and compensation payments are handled separately by the fund. In other words, medical and rehabilitation expenses can be reimbursed even though the employer may not have paid 104 weeks of weekly income benefit payments. It should be emphasized that the 104 weeks is not a calendar waiting period before the fund begins reimbursement. The employer or insurer must have actually paid out the equivalent of 104 weeks of compensation payments.

If the employer or insurer settles the case by stipulation, the statutory deductibles (104 weeks of income benefits) will be subtracted from the weekly benefits and/or total settlement paid in order to compute reimbursement. In computing reimbursement, consideration will be given to that portion of the settlement, which applies toward future medical payments. The fund will take into consideration the medical evidence regarding the likelihood of future medical expenses in computing reimbursement on settled cases.

In all instances, the employer must incur liability above the thresholds in order for the fund to begin reimbursing. This standard applies regardless of whether a case is paid on a weekly basis or lump sum settlement.

The disposition of a case through the use of a "no liability" stipulation precludes fund recovery.

If an employee suffers an injury which entitles an employer/insurer to reimbursement from the fund and then returns to work for the same employer without break in service and suffers another injury which merges with the same condition on which the prior claim was accepted by the fund, a second deductible or threshold does not apply to the last injury period, even if the employer changed insurance carriers. The employer/insurer will only be required to complete the remaining deductible, if any, from the previously reimbursable injury.

H. Reimbursement Agreement

Rule 622-1-.06(1) requires that the employer/insurer and the fund reach an agreement setting forth factual information establishing the employer's right to reimbursement. This reimbursement agreement is initiated by the fund and forwarded to the employer or insurer for signature. This agreement must be approved by the State Board of Workers' Compensation.

When the fund accepts reimbursement liability, the employer/insurer must immediately lower the reserves on the case to the limit of employer's liability (104 weeks of income benefits and not more than $7,500 in medical/rehabilitation payments). Under these circumstances, the reserves normally over these limits will not enter the experience factor of computing the employer's premiums.

I. Reimbursement Request

The fund will require the employer to submit an itemized statement of weekly income benefits paid to the injured employee. In addition, an itemized statement of medical benefits paid on behalf of the employee must be submitted to the Subsequent Injury Trust Fund along with providers' charges or a fee schedule audit. An employer or insurer who can provide a certified counterpart of its electronically-generated or computer-generated pay document which identifies payment date, provider name, provider service, treatment (CPT) codes, and the amount paid, may be relieved from the requirement of providing the Subsequent Injury Trust Fund with copies of providers' charges. The Subsequent Injury Trust Fund may require narrative reports when deemed reasonably necessary by the Subsequent Injury Trust Fund. (Rule 622-1-.06(1), amended April 7, 2002 and December 31,2002.)

Weekly income and medical and rehabilitation benefit reimbursement requests are outlined in Subsequent Injury Trust Fund Form C, "Reimbursement Request". No reimbursement will be made unless a reimbursement request form is completed and signed by the claiming party. This form may be downloaded from the fund's web site www.ganet.org/sitf/.

Rule 662-1-.06 requires that the employer or insurer attest to its efforts to assure that the injured employee is entitled to receive, or continue to receive, workers' compensation benefits. Failure to comply with this regulation may subject a claim to a denial of reimbursement benefits. By the time a case reaches the point where it is accepted by the fund, the necessary information attesting to the employer's efforts to assure that the injured employee is entitled to receive benefits should be in the fund's file. This is a continuous requirement, and even though a case is accepted, the fund must have the assurance of the employer or insurer that the injured employee continues to be entitled to receive compensation.

In completing a reimbursement request, the insurer must show in the appropriate section the total income benefits paid from the day of disability through the date of the request. This includes all payments for total disability, including salary paid in lieu of compensation, temporary partial and permanent partial disability.

In addition, there are categories for other payments. "Other" generally refers to death benefits, stipulated settlements or lump sum advances. The total compensation payment is inserted in the line or space entitled "Total Indemnity to Date."

From the total amount of indemnity paid, subtract benefits paid for 104 weeks (deductible.) If the 104 weeks includes temporary partial disability payments, the payments must be shown separate from the total disability weeks and the employer must provide the fund with a weekly accounting for wage loss (temporary partial benefits) paid

to the employee. On the reimbursement request form, there is a section shown as: "Less 104 Weeks Consisting of". The purpose of this section is to itemize the total number of weeks paid in total disability benefits and the total in temporary partial disability benefits. The sum of these two amounts will be subtracted from the total indemnity paid to date. This will yield the net reimbursable indemnity. In the space below, insert the amount of previous indemnity reimbursement by the fund. Subtract this from the net reimbursable indemnity to arrive at the total indemnity amount requested.

In outlining the medical and rehabilitation expenses on a case, follow the instructions on the reverse side of the reimbursement request form. For costs incurred after January 1, 1991 the fund must be furnished with corresponding medical narratives and rehabilitation reports before reimbursement for such expenses can be considered. For reimbursement requests received after April 7, 2002, an employer's insurer who provides its electronically generated pay document which identifies payment date, provider service, treatment (CPT) codes, and the amount paid may be relieved from providing copies of providers' charges (bills). This provision generally pertains to routine or repetitive treatments; however, the Subsequent Injury Trust Fund may require submittal of narrative reports when it deems it to be reasonably necessary.

If the claims person has any questions about these instructions, a phone call to the fund for clarification is suggested. Any error in the preparation or outlining of the medical bills may result in the reimbursement request processing being delayed or returned. Rule 622-1-.06(1) was amended June 18, 1998, July 11, 2000, April 7, 2002 and again December 31, 2002 allowing for further reduction in paperwork and fund reimbursement of Medicare set-aside trusts.

J. Management of Employee's Claims

The employer or insurer handles the employee's claim throughout the life of the claim. This is true even though the fund has accepted reimbursement responsibility. The employer's or insurer's failure to perform in this capacity may subject the reimbursement claim to denial or suspension of reimbursement. The fund does not have the staffing to handle or manage the employee's claim. In accordance with fund rules, the employer or insurer is required to keep the fund informed about case developments as they occur. The employer/insurer should keep the fund advised on matters such as litigation, appeals and settlements.

The fund will not accept an employer/insurer's attempt to transfer claim management responsibility to the fund after reimbursement has been accepted. The employer/insurer is expected to handle the employee's claim as though the fund were not involved. The employer/insurer should provide benefits consistent with the employee's injury and entitlement according to law.

K. Rehabilitation

The purpose of the Subsequent Injury Trust Fund is to serve as a tool to assist in the rehabilitation process by offering an additional incentive to employers in employing workers with disabilities. Therefore, the fund will not disregard the employer's responsibility to provide effective rehabilitation to the injured worker in those cases where the law does not make rehabilitation services optional.

L. Denied Subsequent Injury Fund Claims

Rule 622-1-.06(2) states that in the event the insurer/self-insurer and the fund fail to reach an agreement, the claiming party may make an application to the State Board of Workers' Compensation for a hearing in regard to the matters at issue through the use of Form WC-14, Notice of Claim/Request for Hearing. This application for hearing must be submitted to the State Board of Workers' Compensation within 90 days of the fund's denial of a claim with a copy forwarded to the fund. The employer may move for reconsideration by submitting to the fund administrator additional information the employer feels may reverse the fund's denial. This additional information should be in the fund's hands no later than 15 days prior to the initially scheduled hearing date. If the parties cannot reach an agreement, either party may request a mediation conference before the State Board of Workers' Compensation. These provisions, however, do not enlarge the (90 day) time period in which the employer or insurer must file a form WC-14 with the State Board of Workers' Compensation challenging the fund's denial.

The employer/insurer should not request a hearing on a claim against the Subsequent Injury Trust Fund until the issue of compensability of the employee's claim is resolved.

M. Settlements Subsequent to Reimbursement Agreements

Pursuant to Code Section 34-9-363.1 and Rule 622-1-.07, an employer or insurer must obtain approval from the fund prior to settling the employee's claim on those cases where a Reimbursement Agreement exists, or the State Board of Workers' Compensation ordered reimbursement.

The employee or his/her attorney should submit a written demand to the employer/insurer and forward a copy to the fund. This copy serves as an advance notice that a settlement authority request from the employer/insurer may be forthcoming; however, the fund cannot begin its evaluation until it receives a formal request from the employer or insurer, along with the employer/insurer's evaluation, recommendations and rationale. Oftentimes delays are encountered when the fund has not been provided with the most current medical and rehabilitation narratives.

The Subsequent Injury Trust Fund authorizes the amount of the settlement it will reimburse the insurer. It will not go above the insurer’s recommended amount. The Subsequent Injury Trust Fund does not negotiate settlements with the injured workers or

their legal representatives. The insurer should make its settlement authority request to the Subsequent Injury Trust Fund, and commence negotiations within the Fund's authority in an expeditious manner.

When a party requests a settlement mediation conference to be scheduled by the State Board of Workers' Compensation on an accepted fund claim, that party should copy the fund with this request (or Form WC-100). This allows the fund to be on advance notice for an earlier evaluation assignment to fund staff.

When the State Board of Workers' Compensation approves a stipulated settlement on a fund-accepted claim and the fund has not granted settlement authority, the reimbursement agreement between the employer/insurer and the fund shall become null and void. The State Board of Workers' Compensation shall, upon petition of the administrator of the fund, issue an order rescinding the reimbursement agreement and may order an employer or insurer to repay the fund any monies the fund previously reimbursed on that case.

N. General Remarks

In most cases, the fund's file is not developed until a substantial period of time has elapsed from the date of injury. Once a claim has been received by the fund, it must then develop the file by reconstructing events that have taken place. The fund may ask the employer/insurer to supply:

1. Employer's First Report of Injury or Occupational Disease (Form WC-1)

2. Copies of pertinent orders, completed Workers' Compensation Board forms or awards from the Board, including Stipulation and Agreements (settlements)

3. Medical reports pertaining to the prior impairment

4. Medical reports pertaining to the subsequent injury

5. Employer's Knowledge affidavit

6. Any additional supporting documents that accompany the knowledge affidavit along with employer's letter certifying that documents were contained in employer's files prior to the subsequent injury date.

7. Rehabilitation reports

In most instances, the resolution of a claim against the fund will depend upon medical questions that deal with the element of merger. This is why the fund frequently requests copies of the hospital admission, operative and discharge summaries. Furthermore, it may request copies of medical reports or information pertaining to the prior impairment to

determine whether or not the prior impairment was the principal factor that materially, substantially and cumulatively aggravated the subsequent injury so as to synergize a greater degree of disability when considered together; and whether or not the employer has been required to pay for that greater disability. O.C.G.A. §34-9-351. SITF v. Harbin Homes, 182 Ga. App. 316, 318 (355 SE2d702)(1987).

References: O.C.G.A. §34-9-351
§34-9-360
§34-9-361
§34-9-363.1

SITF Rules 622-1-.04, 622-1-.05, 622-1-.06, 622-1-.07

Chapter 9
CERTIFIED WORKERS' COMPENSATION PROFESSIONAL
CERTIFICATION PROGRAM

CERTIFICATION PROCEDURE

A. PURPOSE AND APPLICABILITY
To promote professionalism in the industry and improve the handling and continuity of workers' compensation claims, the State Board of Workers' Compensation has created a certification program so that a person involved in any aspect of workers' compensation claims can become a Certified Workers' Compensation Professional (CWCP). This procedure establishes the framework for acquiring and maintaining the certification as a CWCP, including application, training materials, testing, certifying and continuing education. This procedure reflects the desire of the Board to proactively implement a mechanism to create a more uniform standard of knowledge among persons working in the Workers' Compensation field, thus benefiting the entire process of administering Workers' Compensation claims.

B. CERTIFICATION OPTIONAL
Certification as a CWCP is voluntary. It is in no way mandatory for persons working in the Workers' Compensation field in the State of Georgia

C. DEFINITIONS
Unless the context otherwise requires, the terms found in this Certification Procedure are used as defined in §O.C.G.A. 34-9-1. Other terminology is used in accordance with the Georgia Workers' Compensation Code, or industry usage, if not defined in the Georgia Workers' Compensation Code.

CWCP – Certified Workers' Compensation Professional

Administrator - the administrator of the Certification Program under purview of the Licensure & Quality Assurance Division of the State Board of Workers' Compensation and the Certification Committee.

Certification Committee - the committee appointed by the Board to administer the certification of CWCP course sponsors and oversee the administration of the CWCP course. The committee shall consist of five (5) members. Three (3) of the members shall be appointed from the Licensure and Self-Insurance Committee of the SBWC Advisory Council. Two (2) of the members shall be Board personnel.

D. FILING OF FORMS

1. Unless otherwise indicated and to the extent provided, each filing required under this Certification Procedure is to be made on forms specified by this procedure.
2. Forms may be reproduced and may be altered to accommodate manual or automated processing provided the same information is presented in the same order as in the forms herein promulgated.
3. Upon specific request by the person required to make such filing, the Certification Committee may, with the approval of the Administrator, approve a method of electronic filing.

E. APPLICATION FOR CERTIFICATION

1. To be eligible for certification as a CWCP, an applicant must make proper application to an approved CWCP training program, and pay all required fees.
2. A person registered to take the CWCP course who has not completed the requirements for certification within one year after beginning the course must submit a new application to be considered for certification.
3. In lieu of E. 1. and 2. above, the applicant may present satisfactory evidence to the Certification Committee and the Administrator in the form of a college transcript from an accredited college or university of successful completion of ten (10) quarter hours (or the equivalent) of Workers' Compensation courses. These courses must include such topics as set out in Section C (1), Subparagraph (4) of the Certification of CWCP Training Course Sponsors Section.

F. EXAMINATIONS

1. All applicants for certification as CWCP are required to submit to an examination given by the course sponsor. The examination shall be given following the completion of required course work, at times determined by the course sponsor.
2. No person shall be eligible to take a CWCP examination unless that person has properly made application to take an approved CWCP course, paid the tuition fee, and completed the required course work.
3. The format of the test shall be approved by the Certification Committee.
4. The passing grade on examination for certification for CWCP shall be seventy (70) percent.
5. Any person making a failing grade on the examination shall be offered the opportunity to re-take a similar (but not the same) examination. If a passing grade is not made on the second examination, and the person wishes to pursue CWCP certification, that person must make application to re-take the training course, pay the required tuition fee, and complete the required training, including passing the CWCP examination.
6. Upon satisfactory completion of the course work and the passing of the examination, the student shall be issued a CWCP certificate.

G. CONTINUING EDUCATION FOR RETENTION OF CERTIFICATION

1. Ten (10) hours of Continuing Education are required each year in order to retain the Certification as a CWCP (Re-certification), and must be completed prior to December 31st of the year following certification.
2. Upon completion of the Continuing Education requirement, the CWCP certificate-holder shall be provided notification of re-certification by the course sponsor.
3. Failure to meet the requirements to re-certify will require the certificate holder to reapply and retake the CWCP course.
4. A record of registration and attendance must be maintained by the course sponsor throughout the entire course.

CERTIFICATION OF CWCP TRAINING COURSE SPONSORS

A. COURSE SPONSORS

CWCP Training courses may be sponsored by any person or entity, including but not limited to, colleges and universities, insurers, adult education centers and associations.

B. TRAINING COURSE REQUIREMENTS

a. Except as otherwise provided, the CWCP certification training course must contain a minimum of forty (40) hours of instruction and must meet the following standards:
(a) Reference materials such as the Georgia Workers' Compensation Code, all rules and regulations promulgated under the Georgia Workers' Compensation Code and sample forms there under, training manuals, study manuals as appropriate, programmed textual materials, and other illustrative materials shall be readily available for student use.
b. All classrooms used shall be rooms separate from other activities while instruction is being given and shall provide comfortable physical facilities for the students. Such classrooms must be properly equipped with sufficient desk or table space to accommodate the number of students taking the course and must contain sufficient teaching aids to facilitate a learning atmosphere for those students.
c. The subject matter of the certification course must pertain to materials relevant for CWCP certification for which applicant has applied or is intending to apply and must include all of the following to such extent as the information applies to the CWCP certification sought by the applicant.

Historical Background
a. Overview of Georgia Law
b. Human Resources in Claim Handling
c. Investigations
d. Fraud Awareness
e. Reserves/Estimates
f. Medical Care
g. Disability Management and Rehabilitation
h. Financial Recovery
i. Litigation and Mediation
j. Forms and Procedures
k. Communication

And such additional material as the Certification Committee may from time to time require by notice to the course sponsors.

(d.) All required course work must be completed within six (6) weeks of the beginning of the class. Special exceptions may be granted at the discretion of the Certification Committee.

(e.) There shall be a minimum of fourteen (14) classroom hours.

(f) Course sponsors must have their courses certified by the Certification Committee prior to beginning any course. To request this certification, the sponsor shall file with the Licensure and Quality Assurance Division of the State Board of Workers' Compensation, the following:

a. An outline of the proposed certification training course, including instructional time for each major course component.
b. An outline of a proposed Continuing Education course for annual CWCP re-certification purposes
c. A list of all instructional material to be used
d. A description of the facility to be used as a classroom.
e. A statement that adequate parking facilities are available and that handicap access is provided.
f. The name or names of the instructors and a description of the instructor's qualifications.
g. The Certification Committee may require further detail of the proposed course or filing of copies of any instructional materials to be used as are necessary to determine the adequacy of the proposed instruction.

EMPLOYER REFERENCE SECTION

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Chapter 1

COVERAGE

A. Employer's Duty to Insure Payment of Compensation

O.C.G.A. §34-9-120 states that "Every employer subject to the compensation provisions of this chapter shall insure the payment of compensation to his employees in the manner provided in this article; and, while such insurance remains in force, he or those conducting his business shall be liable to any employee for personal injury or death by accident only to the extent and in the manner specified in this article."

Further, pursuant to O.C.G.A. §34-9-121(a) "...every employer subject to the provisions of this chapter...shall secure and maintain full insurance against such employer's liability for payment of compensation under this article, such insurance to be secured from some corporation, association, or organization licensed by law to transact the business of workers' compensation insurance in this state or from some mutual insurance association formed by a group of employers so licensed; or such employer shall furnish the Board with satisfactory proof of such employer's financial ability to pay the compensation directly in the amount and manner and when due, as provided for in this chapter."

B. Self-Insurance (O.C.G.A. §34-9-127 and §34-9-380 et seq.)

An employer desiring to become self-insured must apply by completing the Confidential Application For Private Self-Insuring Employers and Hospital Authorities and be accepted by the Board and the Georgia Self-Insurers Guaranty Trust Fund, O.C.G.A. §34-9-382. All questions must be answered fully and all financial information will be treated as strictly confidential. Each application must be submitted in duplicate, with the company's audited financial statements for the last three years and a filing fee of $500 payable to the Georgia Self-Insurers Guaranty Trust Fund. Each company is considered on its own merits, but strict attention is paid to the size of company, financial stability, amount of annual premium, number of employees, yearly payroll and the company's loss history. If a company is accepted as a self-insurer, a bond or letter of credit shall be posted in an amount not less than $250,000.

Counties, municipalities and other political subdivisions may qualify as self-insurers. Permission for self-insurance by municipalities and political subdivisions may be granted by application to the Board, on a form entitled Confidential Application for Governmental Self-Insuring Employers and without deposit of surety bonds. Assurance must be given the Board that provision will be made for payment of all workers' compensation liabilities.

Whenever an employer has complied with the provisions of the Workers' Compensation Act relating to self-insurance, the Board shall issue to such employer a certificate which

shall remain in force for a period fixed by the Board; but the Board may, upon at least 60 days notice to the employer and after a hearing, revoke the certificate upon satisfactory evidence for such revocation having been presented.

In order for a certificate to be granted by the Board under O.C.G.A. §34-9-127 and §34-9-382, the employer desiring to become a self-insurer must designate an office for the handling of claims (see Form WC-121 and Board Rule 127.) Every service organization or office handling claims for self-insurance under the law shall be staffed during normal working hours and be available for immediate telephone contact with the Board and the public. During normal working hours at this office, at least one staff member shall be authorized to execute negotiable instruments for the payment of compensation. Certificates will be continuous unless the self-insurer fails to meet the requirements of the Board.

C. Group Self-Insurers (O.C.G.A. §34-9-150)

It is the intent of the General Assembly to provide an alternative mechanism through which bona fide members of the following may extend workers' compensation benefits to their employees through group self-insurance programs as defined in O.C.G.A. §34-9-151: (a) counties; (b) hospital authorities; (c) municipalities; (d) professional associations; (e) school Boards; and (f) trade associations. Permission for self-insurance by municipalities and political subdivisions may be granted by application and without deposit of surety bonds. Assurance must be given to the Board that provision will be made for payment of all workers' compensation liabilities.

Group Self-Insurance Funds operating pursuant to the Georgia Workers' Compensation Act shall file with the Board a separate report, for each insured member employer, on Standard Coverage Form WC-11 on or before the effective date of coverage.

1. Group Self-Insurance Funds shall file a separate Form WC-11 for each insured member of the fund.

2. The filing of Form WC-11 is evidence that coverage is in effect until superseded or terminated.

3. The filing of a cancellation on Form WC-11 is evidence that coverage is terminated effective not less than 15 days after filing.

5. If the self-insured member employer operates under different trade names, a separate Form WC-11 must be filed for each trade name, properly cross-referenced.

D. Notice to or Knowledge of Accident (O.C.G.A. §34-9-123)

All policies insuring the payment of compensation, including all contracts of mutual, reciprocal or interinsurance must contain a clause to the effect that, as between the employer and insurer, the notice to or knowledge of the occurrence of the injury on the part of the employer shall be deemed notice or knowledge, as the case may be, on the part of the insurer.

E. Filing by Employer of Evidence of Compliance with Insurance Requirements (O.C.G.A. §34-9-126)

Every employer subject to the compensation provisions of the Workers' Compensation Act shall file with the Board in the form prescribed by the Board, annually or as often as the Board may deem necessary, evidence satisfactory to the Board of their compliance with O.C.G.A. §34-9-121.

Any employer subject to the compensation provisions of the Workers' Compensation Act who refuses or willfully neglects to comply with the provisions above shall be guilty of a misdemeanor. The Board may assess compensation against such employer in an amount 10% greater than that provided for in this chapter and, in addition to the increased compensation, shall also fix a reasonable attorney's fee to be paid by the employer to the representative of the employee. The attorney's fee and the increased compensation shall be due and payable at once.

F. Payment of Compensation to Employees in Service of More Than One Employer (O.C.G.A. §34-9-224)

Whenever any employee whose injury or death is compensable under this chapter shall at the time of the injury be in the joint service of two or more employers, such employers shall contribute to the payment of such compensation in proportion to their wage liability to such employee.

G. Payment of Compensation for Death Resulting From Injury (O.C.G.A. §34-9-265)

1. If death results instantly from an accident arising out of and in the course of employment or if during the period of disability caused by an accident death results, the compensation under this chapter shall be as follows:

    a. The employer shall, in addition to any other compensation, pay the reasonable expenses of the employee's burial not to exceed $7,500. If the employee leaves no dependents, this shall be the only compensation.

b. The employer shall pay the dependents of the deceased employee, who are wholly dependent on his/her earnings for support at the time of injury, a weekly compensation equal to the compensation which is provided for in O.C.G.A. §34-9-261 for total incapacity.

c. If the employee leaves dependents only partially dependent on his/her earnings for their support at the time of his injury, the weekly compensation for these dependents shall be in the same proportion to the compensation for persons wholly dependent; as the average amount contributed weekly by the deceased weekly wage at the time of his or her injury.

d. When weekly payments have been made to an injured employee before his/her death, compensation to dependents shall begin on the date of the last of such payments; but the number of weekly payments made to the injured employee under Code Section §34-9-261, §34-9-262, or §34-9-263 shall be subtracted from the maximum 400-week period of dependency of a spouse provided by Code Section §34-9-13, and in no case shall payments be made to dependents except during dependency.

e. The total compensation payable under this section to a surviving spouse as a sole dependent at the time of death and where there is no other dependent for one year or less after the death of the employee shall in no case exceed $125,000.

f. If there are no dependents in a compensable death case, the insurer or self-insurer shall pay the State Board of Workers' Compensation one-half of the benefits which would have been payable to such dependents or $10,000.00, whichever is less. All such funds paid to the Board shall be deposited in the general fund of the state treasury. If after such payment has been made, it is determined that a dependent or dependents qualified to receive benefits exist, then the insurer or self-insurer shall be entitled to reimbursement by refund for money collected in error.

H. Applicability of Chapter IX to Occupational Disease; Circumstances in Which Death or Disability Resulting From Occupational Disease is Compensable (O.C.G.A. §34-9-281)

1. Where the employer and employee are subject to this chapter, the disablement or death of an employee resulting from an occupational disease shall be treated as the occurrence of an injury by accident and the employee or, in the case of his or her death, the employee's dependents shall be entitled to compensation as provided by this chapter. The practice and procedure prescribed in this chapter shall apply to all the proceedings under this article except as otherwise provided.

2. Except as otherwise provided in O.C.G.A. §34-9-281, an employer shall be liable for compensation under this article only where:

a. The disease arose out of and in the course of the employment in which the employee was engaged under such employer, was contracted while the employee was so engaged, and has resulted from a hazard characteristic of the employment in excess of the hazards of such disease attending employment in general.

b. The claim for disablement is filed within one year after the date the employee knew or, in the exercise of reasonable diligence, should have known of the disablement and its relationship to the employment; but in no event shall the claim for disablement be filed in excess of seven years after the last injurious exposure to the hazard of such disease in such employment. In cases of death where the cause of action was not barred during the employee's life, the claim must be filed within one year of the date of death.

I. Insurance with More Than One Company; Use of Servicing Agents and Third Party Administrators (Board Rules 121 and 131)

1. A compensation policy must cover all of the operations of an employer. An employer has the right to place insurance with more than one insurer; but if this is done with respect to distinct operations, the policies must be concurrent and the written portions must read alike. If there is any difference in coverage, it can be expressed as applying to a fractional part thereof. If an employer has more than one place of business, each operation can be covered separately unless the business is interchangeable. Each insurer on the risk must cover alike all the employees coming under the law. Each insurer shall inform the Board of the proper address to be used by the Board for serving all hearing notices and other Board notices.

2. Notice of Use of Servicing Agent or Third Party Administrator (Form WC- 121.)

An insurer, self-insurer, or self-insurance fund shall file this form to give notice of the employment of a servicing agent or third party administrator, and of the termination of services of same. When obtaining the services of a servicing agent or third party administrator, this form shall be filed no later than the commencement date of those services. When terminating the services of a servicing agent or third party administrator, this form shall be filed no later than 30 days prior to the date of the cessation of services.

3. The transfer of files from one third party administrator/servicing agent to another must be handled in a professional and timely manner.

(i) Open indemnity files must be current as of the date of transfer and the transferring (former) third party administrator/servicing agent must include in the

file a complete current Form WC-4 (completed within the last 30 days) reflecting all payments made as of the date of transfer. The transferring third party administrator/servicing agent must at the date of transfer provide the receiving third party administrator with a payment history on all Medical Only claims with an occurrence date of 90 days or less as of the date of transfer. Penalties for noncompliance by the transferring third party administrator/servicing agent would be in accordance with O.C.G.A. § 34-9-18(a).

(ii) The receiving (new) third party administrator/servicing agent must notify all active (open) claimants of the change in administration within 14 days of receiving the files. Vendors must be notified within 60 days of receipt of medical bills or service invoices.

4. Employers unable to obtain workers' compensation insurance coverage in any other manner may apply to the assigned risk pool:

National Council on Compensation Insurance, Inc.
750 Park of Commerce Drive
Boca Raton, FL 33487
Phone: 1-800-622-4123

Every employer insured by a licensed insurer shall have proof of coverage documented by its insurer directly with a Licensed Rating Organization through their policy information system. Every employee leasing company shall have proof of coverage documented with a Licensed Rating Organization of the initiation or termination of any contractual relationship with a client company; for the purposes of the Rule, the term employee leasing company shall refer to both: (1) any employee leasing company as defined in O.C.G.A. §34-8-32; and (2) any professional employer organization as defined in §O.C.G.A. §34-7-6. Reports will be made to the Licensed Rating Organization pursuant to procedures outlined by the Licensed Rating Organization and approved by the Georgia State Board of Workers' Compensation.

a. The proof of coverage documented with a Licensed Rating Organization is evidence that coverage is in effect until superseded or terminated.

b. Termination
   (i) Non-renewals
   The expiration date documented by a Licensed Rating Organization shall be considered the date of termination on all non-renewals.

   (ii) A Mid-term cancellation documented with a Licensed Rating

Organization is evidence that coverage is terminated, effective not less than 15 days after filing except where the provisions of Title 33 provide for an earlier effective date.

Chapter 2

REPORTING REQUIREMENTS FOR EMPLOYERS
CLAIMS FORMS (BOARD RULE 61)

A. Form WC-1 Employer's First Report of Injury or Occupational Disease

Employer should complete Section A and the wage statement on the back of the form immediately upon knowledge of an injury and submit the form to their insurer. The insurer then completes Form WC-1 for cases involving more than seven days of lost time and files it with the Board. Cases with seven or less days of lost time should be reported on Form WC-26. For cases previously reported on Form WC-26 as medical only and where there is subsequent lost time of more than seven days stamp Form WC-1, "MEDICAL ONLY" and file with the Board.

Insurers and self-insured employers shall complete Section B or C and mail the original to the Board and a copy to the employee within 21 days of the employer's knowledge of disability.

B. Additional Forms to be Filed by Insurers/Self-Insurers

1. Form WC-2 Notice of Payment or Suspension of Benefits. Use Form WC-2 to commence or suspend payment of weekly benefits after filing an Employer's First Report of Injury (Form WC-1). For all other cases, including any change in weekly benefits, classification or rating of disability, file Form WC-2. Furnish a copy to injured worker.

2. Form WC-2a Notice of Payment or Suspension of Death Benefits. Use in death cases in lieu of Form WC-2. Use when changes in dependency occur.

3. Form WC-3 Notice to Controvert Payment of Compensation. Complete Form WC-3 to controvert where a Form WC-1 has previously been filed. Furnish copies to the injured worker and any other person with a financial interest in the claim (see Subsections (d), (h), and (i) of O.C.G.A. §34-9-221.)

4. Form WC-4 Case Progress Report. File as follows:

   a. Within 180 days of the first date of disability;

   b. Within 30 days from last payment for closure;

   c. Upon request of the Board;

   d. Every 12 months from the date of the last filing of a WC-4 on all open cases;

e. To reopen a case;

f. With all settlement documents; and

g. Within 90 days of receipt of an open case by the new third party administrator.

5. Form WC-6 Wage Statement. The employer/insurer must file this form when the weekly benefit is less than the maximum under O.C.G.A. §34-9-262 and furnish a copy to the employee. If a party makes a written request of the employer/insurer, then the employer must send the requesting party a completed Form WC-6 within 30 days, but should not send a copy to the Board.

6. Form WC-10 Notice of Election or Rejection of Workers' Compensation Coverage (O.C.G.A. §34-9-2.1,2.2, 2.3, Rule 2).

a. A sole proprietor or partner must file this form to elect coverage under the provisions of O.C.G.A. §34-9-2.2.

b. The employer/insurer must file this form in order that the corporate officer or limited liability company member be exempt from coverage, or to revoke their previously filed exemption. Rejection becomes effective the date of filing with the insurer, if there is one; and, if none, with the Board.

c. The farm labor employer must file this form in order to request coverage for farm laborers, or to revoke their previously filed request.

d. Pursuant to Rule 2(d) all WC-103 filed with the Board must be renewed every five years.

7. Form WC-20(a) Medical Report (may also use HCFA 1500, HCFC 1450 or UB 92). The attending physician or other practitioner completes the report to document treatment and forwards it along with office notes and other narratives to the employer/insurer as follows:

a. Within seven days of initial treatment;

b. Upon the employee's discharge by the attending physician or at least every three months until the employee is discharged;

c. Upon the employee's release to return to work; and

d. When a permanent partial disability rating is determined.

The employer/insurer shall file the report including office notes and narratives with the Board within 10 days after receipt as follows:

a. When the report contains a permanent partial disability rating;

b. When a rehabilitation plan is filed with the Board. All medical reports and attachments which have not been filed with the Board must be filed at the time the plan is filed with the Board, and all medical reports and attachments received thereafter shall be filed with the Board within 10 days of receipt;

c. Upon request of the Board; and

d. To comply with other rules and regulations of the Board.

The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports except in compliance with Board Rules 61(b)(12),(15), and (16) and 200(c).

8. Medical Reports.

a. The employer/insurer shall file with the Board all medical reports, narratives and other correspondence only as provided in Board Rules 61(b)(12),(15), and (16) and 200(c).

b. The employer/insurer shall file all required medical reports not previously filed.

9. Form WC-26 Yearly Report of Medical Only Cases. File on or before the 31st of January following the end of the calendar year in respect to payments for injuries not reported on Form WC-1. File annually even if no reportable injuries or payment occurred during the reporting year.

10. Form WC-R1 Request for Rehabilitation. The employer/insurer shall file:

a. Within 48 hours of a compensable catastrophic injury, simultaneously with the Form WC-1, naming a catastrophic rehabilitation supplier.

b. Within 15 days of notification that rehabilitation is required to request a rehabilitation supplier.

c. When the employer/insurer requests a rehabilitation supplier for cases with dates of injury prior to July 1, 1992.

d. When the employer/insurer requests a change of rehabilitation supplier.

e. To request reopening of rehabilitation.

f. Upon request of the Board.

11. Any person who willfully fails to file any form or report required by the Board, fails to follow any order or directive of the Board or any of its members or Administrative Law Judges or violates any rule or regulation of the Board shall be subject to a civil penalty of not less than $100 nor more than $1,000 per violation. The assessed penalty becomes final unless the person fined files a written request for a hearing within ten days of the assessment. Any person, firm, or corporation who willfully makes any false or misleading statement or representation for the purpose of obtaining or denying benefits shall be guilty of a misdemeanor and upon conviction may be assessed a civil penalty of not less than $1,000 nor more than $10,000 per violation or imprisonment not to exceed 12 months or by both such fine and imprisonment (O.C.G.A. §§34-9-18 & 19).

Chapter 3

METHOD OF PROVIDING MEDICAL TREATMENT

A. O.C.G.A. §34-9-201(b)

O.C.G.A. §34-9-201(b) of the Workers' Compensation Law provides:

1. The employer may satisfy the requirements for furnishing medical care in one of the following manners:

   a. The employer shall maintain a list of at least six non-associated physicians or professional associations or corporations of physicians who are reasonably accessible to employees. This list shall be known as the "Panel of Physicians." At least one of the physicians must practice the specialty of orthopedic surgery. Not more than two physicians on the panel shall be from industrial clinics. One physician on the panel must be a minority. The employee may make one change from one physician to another on the same panel without prior authorization from the Board.

      However, the Board may grant exceptions to the required size of the panel where it is demonstrated that more than six physicians or groups of physicians are not reasonably accessible. In the event that the Board has granted an exception to any panel requirements, the exception must be posted in the same location as the panel.

   b. The employer may maintain a list of at least 10 physicians or professional associations reasonably accessible to the employees and providing the same types of healthcare services specified in Board Rule 201(a) (1) and the following healthcare services: general surgeons and chiropractors. This list shall be known as the "Conformed Panel of Physicians."

   c. An employer or the workers' compensation insurer of an employer may contract with a managed care organization certified by the Board. Medical services provided in this manner shall be known as "Managed Care Organization Procedures." Employees shall be given notice of the managed care organization's network of eligible medical service providers and information regarding the contract and manner of receiving medical services, including a toll free 24-hour telephone number that informs employees of available services.

   d. An employee may obtain the services of any physician from the panel and may thereafter elect to change to another physician on the panel without prior authorization of the Board. The physician so selected will become the primary treating physician in control of the employee's medical care.

O.C.G.A. §34-9-201(g) provides that the Board shall ensure, whenever feasible, the participation of minority physicians on panels of physicians and managed care organizations maintained by employers. For the definition of "minority," see chapter 6 (A) (1) of this manual.

2. Businesses with multiple locations should choose physicians for their panel who are in close proximity to each individual location. The employer should contact each physician (group, professional association, or professional corporation) prior to listing them on the posted panel, conformed panel, or within the managed care organization provider network procedures to assure their willingness to treat workers' compensation patients claims.

3. Notwithstanding any selection made pursuant to his or her rights under the posted panel, conformed panel, or managed care organization procedures, an employee, after a compensable injury and within 120 days of receipt of any income benefits, shall have the right to one examination at a reasonable time and place, within this state or within 50 miles of the employee's residence, by a duly qualified physician or surgeon designated by the employee and to be paid for by the employer/insurer. Such examination shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury unless the costs of such diagnostic procedures which are in excess of $250 are paid for by a party other than the employer or the insurer.

4. If an emergency situation arises in which there is not time to comply with selection requirements, the injured employee is authorized to seek treatment from a physician of his or her choice; this authorization lasts for the duration of the emergency. An emergency may be defined as "an unforeseen occurrence or combination of circumstances which calls for immediate action or remedy; pressing necessity; exigency." All follow-up medical care should be supplied by a physician from the panel, conformed panel (or the authorized treating physician's referral), or from the managed care organization’s provider network.

5. The "Panel of Physicians," "Conformed Panel of Physicians," or "Managed Care Organization Procedures" must be posted in prominent locations accessible to all employees such as bulletin Boards, employees' break station, time card clock, personnel office, etc. The panel, conformed panel, or managed care organization procedures should also be posted at remote job sites where employees are regularly required to work away from their principal place of business. The employer shall take all reasonable measures to ensure that employees:

   a. Understand the function of the panel, conformed panel, or managed care organization procedures;

b. Understand his/her right to select a physician from the panel, conformed panel, or managed care organization in case of an on-the-job injury and to make a one time change of physician within the panel without Board approval.

c. Are given appropriate assistance in contacting panel, conformed panel, or managed care organization members when necessary.

B. Changes in Treatment

Except as provided in Subsection (b) of O.C.G.A. §34-9-201, changes in physician or treatments are made only by agreement of the parties or by order of the Board. Board authorized changes are effective on the date the request is filed with the Board, unless a later date is specified in the Board's order. The request for change in physician shall include the address of the physician to whom a change or additional treatment is desired. A request for, or objection to, a change of physician or additional treatment must be filed on Form WC-200b, with supporting documentation attached and with copies provided to all parties. If the argument in support of, or in objection to, the change is based on testimony, an affidavit must be attached to the form and, if the argument refers to documents, a copy of the documents must be attached. Parties are required to make a "good faith" effort to resolve a change of physician dispute prior to filing a Form WC-200b.

Chapter 4

MEDICAL

A. Medical Reports (Board Rule 200 (a)(b)(c))

The employer/insurer shall not file a medical reports with the Board, except as follows:

a. When the report contains a permanent partial disability rating;

b. When a Rehabilitation Plan is filed with the Board. All medical reports and attachments which have not been filed with the Board must be filed at the time the plan is filed with the Board, and all medical reports and attachments received thereafter shall be filed with the Board within 10 days of receipt;

c. Upon request of the Board; and

d. To comply with other rules and regulations of the Board.

The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports with the Board except in compliance with Board Rules 61(b)(12),(15), and (16) and 200(c).

The employee shall, upon the request of the employer/insurer, furnish copies of all medical records and reports in his or her possession within 30 days of the date of the request, the cost of which shall be charged to the employer/insurer according to the fee schedule. The employer/insurer shall, upon the request of the employee, furnish copies of all medical reports in their possession within 30 days of the date of the request, at no expense to employee. Upon failure of either party to furnish information as provided above, the physician or other medical providers shall, upon request, furnish copies of all medical reports and bills in their possession at no expense to the employee, the cost of such records shall be billed according to the fee schedule, and charged against the party determined to be responsible for payment of medical expenses (see Board Rule 200 (c).)

B. Independent Medical Examinations (IME) (Board Rule 202)

1. An IME may include physical, psychiatric and psychological examinations. An examination may also include reasonable and necessary testing, including functional capacity evaluations, as recommended by the examining physician.

2. The employer/insurer shall give the employee and /or his/her attorney ten days written notice of the time and place of any requested examination. Advance payment of required travel expenses shall accompany such notice.

3. The employer/insurer shall not suspend weekly benefits for refusal of the employee to submit to examination or cooperate with treatment except by order of the Board.

4. The employer/insurer cannot restrict treatment to the panel of physicians, conformed panel, or managed care organization where they have controverted the claim. However, if the controverted claim is subsequently found to be or is accepted as compensable, the employee is authorized to select one of the physicians who has provided treatment for the work-related injury prior to the finding or acceptance of compensability, and such physician becomes the authorized treating physician. The employee may thereafter make one change from that physician to another physician without approval of the employer and without an order of the Board. However, any further change of physician or treatment must be in accordance with O.C.G.A. §34-9-200 and Board Rule 200.

C. Payment of Medical Expenses (Board Rule 203(a))

The insurer/self-insurer are responsible for the payment of all reasonable, necessary, and related medical expenses prescribed by an authorized treating physician, including diagnostic testing to determine causation the insurer/self-insurer may automatically conform charges according to the fee schedule adopted by the Board and shall pay within 30 days from the date of receipt of the charges. The insurer/self-insurer must provide written notification to the medical provider within 30 days of the receipt of medical charges, the reasons for non-payment of medical expenses and a written itemization of any documents or other information needed to process the claim for medical benefits. Failure of the insurer/self-insurer to notify the medical provider in writing within 30 days of the receipt of the charges of the need for further documentation will be deemed a waiver of the right to defend a claim for failure to pay charges in a timely fashion on the ground that the charges were not accompanied with the proper documentation. However, this waiver does not extend to any other defense the insurer/self-insurer may have with respect to a claim of untimely payment. If the insurer/self-insurer is controverting the medical expenses, they must file a Form WC-3, Notice to Controvert, with the Board within the 30 days allowed for payment. All persons having a financial interest, including the physician, must receive a copy of the Form WC-3.

Medical expenses shall include, but are not limited to, the reasonable cost of travel between the employee's home and the place of examination or treatment, including physical therapy appointments or the pharmacy visits. When travel is by private vehicle, the rate of mileage shall be 28 cents per mile. Travel expenses beyond the employee's home city shall include the actual cost of meals and lodging. Travel expenses shall further include the actual reasonable cost of meals when total elapsed time of the trip to obtain outpatient treatment exceeds four hours per visit. Cost of meals shall not exceed $30 per

day. Medical expenses include the reasonable cost of attendant care directed by the treating physician during travel and convalescence.

Reasonable medical charges must be paid within 30 days of the date that the insurer/self-insurer receive the charges and reports. If the medical charges are not paid within 30 days of the receipt of the documentation required by the Board, the following penalties will apply automatically: A 10% penalty on reasonable medical charges paid after 30 days but before 60 days; a 20% penalty on reasonable medical charges paid after 60 days but before 90 days; and, in addition to the 20% penalty, a 12% per annum interest rate is charged on reasonable medical charges paid after 90 days. The penalties and interest are payable directly to the provider.

D. Procedure When Amount of Medical Expenses, Necessity of Treatment or Authorized Treatment are Disputed (Board Rule 203(b), 205)

Medical expenses shall be limited to the usual, customary and reasonable charges. Employers/insurers may automatically conform charges according to the fee schedule adopted by the Board and the charges listed in the fee schedule shall be presumed usual, customary and reasonable and shall be paid within 30 days from the date of receipt of the charges. Employer/insurer shall not unilaterally change any CPT-4 code of the provider. All charges automatically conformed according to the fee schedule adopted by the Board shall be for the CPT-4 code listed by the provider. In situations where charges have been reduced or payment of a bill denied, the insurer, self-insurer, or third party administrator shall provide an Explanation of Benefits with payment information explaining why the charge has been reduced or disallowed, along with a narrative explanation of each Explanation of Benefit code used.

Any health service provider whose fee is reduced to conform to the fee schedule may request peer review of charges or treatment and present evidence as to the reasonableness of his/her charges or treatment. If the dispute is not resolved through the recommendations of peer review then a mediation or hearing may be requested. An employer/insurer, who disputes that any charge is the usual, customary and reasonable charge prevailing in the State of Georgia shall, within 30 days of the receipt of the charges, file with the appropriate peer review committee a request for review of only those specific charges which are disputed. No CPT, DRG, or ICD-9 Codes are to be changed without first notifying, and then obtaining permission from, the authorized treating physician/hospital. Any physician/hospital whose charges are disputed and any party disputing such charges must comply with requirements of law, Board rules, and, if applicable, rules of the appropriate peer review committee before the Board will order payment of any disputed charges. The injured worker's name and address must be included in the request for peer review. Effective July 1, 1992, Board Rule 203(b) was changed to allow all parties to correspond directly with Board approved peer review committees. These committees may be contacted at the following addresses.

Dr. Mitchell S. Nudelman
Medical Director Solutions, L.L.C.
577 Seminole Drive
Marietta, GA 30060
(770) 499-0398 FAX (770) 499-8299

Dr. Eric Krohne, Executive Director
Georgia Chiropractic Association, Inc.
3772 Pleasantdale Road, Suite 175
Atlanta, GA 30340
(770) 723-1100

Ms. Pat Garner, Executive Director
Georgia Psychological Association
1750 Century Circle, Ste. 10
Atlanta, GA 30345
(404) 634-6272 FAX (404) 634-8230

Mr. Marvin Gross, M.S., P.T., Principal
Mr. Stuart Platt, M.S.P.T., P.T., Principal
Appropriate Utilization Group, LLC
1086 Burton Drive
Atlanta, GA 30329
(404) 728-1974

Ms. Ruth Brunder, President
Georgia Home Care Association
168 N. Johnson Street, Suite 304
Dallas, GA 30132
(770) 445-3180 ext. 32

Within 30 days of the date that a decision is issued by a peer review organization, the employer/insurer shall either make payment of disputed charges based upon the recommendations of the peer review committee or request mediation. If the dispute is not resolved through mediation, a hearing may be requested. The peer review committee shall serve a copy of its decision upon the employee, or if represented by counsel, on the employee's attorney. A physician whose fee has been reduced by the peer review committee shall have 30 days from the date that the recommendation is mailed to request mediation. If the dispute is not resolved through mediation, a hearing may be requested. In the event of a hearing, the recommendations of the peer review committee shall be prima facie proof of the usual, customary and reasonable charges.

E. Reimbursement of Group Carrier or Other Healthcare Provider (Board Rule 206)

A Form WC-206 shall be submitted to the Board by the party seeking reimbursement at any time during the pendency of a claim. Copies shall also be sent by the party requesting reimbursement to all counsel and unrepresented parties. When the Board receives a request for reimbursement and designation as a party at interest, the Board will provide the party requesting reimbursement with notice of any hearing or other Board proceeding that has been initiated by a party to the claim.

Chapter 5

INSPECTION OF PREMISES, NONCOMPLIANCE, AND FALSE OR MISLEADING STATEMENTS OR REPRESENTATIONS (Workers' Compensation Fraud)

A. Enforcement Division

In accordance with O.C.G.A. §34-9-24, there is established within the Board, a fraud and compliance division. Pursuant to Board Rule 24 this division shall be known as the Enforcement Division. The Enforcement Division shall assist the Board in administratively investigating allegations of fraud and noncompliance and in developing and implementing programs to prevent fraud and abuse in workers' compensation. The Enforcement Division is a certified law enforcement agency with the authority to execute search warrants and make arrests pursuant to warrants being issued.

In the absence of fraud or malice, no person or entity who furnishes to the Board information relevant to suspected fraud or noncompliance with regards to workers' compensation laws shall be liable for damages in regards to the furnishing of said information.

Board Rule 24 outlines the procedure utilized by Enforcement Division to request a hearing. Subsection (b) of Rule 24 authorizes the Enforcement Division to request a hearing before an administrative law judge for the assessment of civil penalties against any person or entity for violating provisions of Title 34-9 by filing Board Form WC-24. Board Form WC-24 is for use only by the Enforcement Division to request a hearing. All hearings will be conducted pursuant to O.C.G.A. §34-9-102 and Board Rule 102. Subsection (c) of Rule 24 states that all appeals of a decision of the administrative law judge concerning civil penalties for violations of Title 34-9 must follow O.C.G.A. §34-9-103 and O.C.G.A. §34-9-105 and their accompanying Board Rules.

Board Rule 24 provides the Enforcement Division the authority to issue a Board directive when investigating incidences of noncompliance. Pursuant to subsection (d) during an investigation of alleged noncompliance with the provisions of Chapter 9 of Title 34, the Enforcement Division of the State Board of Workers' Compensation may issue a notice for verification of coverage directing the employer, within fifteen days of the date of the notice, to provide either proof of worker's compensation coverage or proof as to why the employer is not subject to the Act. This notice shall be considered a directive of the Board.

B. Authority to Inspect

According to O.C.G.A. §34-9-128, the Board and its authorized representatives shall have the power and authority to enter any place of employment and to inspect the same,

together with all employment, payroll, and injury records at any reasonable time for the purpose of investigating compliance with this chapter and making inspections for the proper enforcement of this chapter.

The willful refusal of an employer to permit inspections and investigations as stated in this Code Section or to comply with O.C.G.A. §34-9-120, O.C.G.A. §34-9-121, and O.C.G.A §34-9-126 after being notified of non-compliance by the Board may subject the employer to a penalty to be assessed by the Board not exceeding $50.00 per day so long as the refusal shall continue.

C. Compliance with Insurance Requirements

According to O.C.G.A. §34-9-121(a) unless otherwise ordered or permitted by the Board, every employer subject to the provisions of this chapter relative to the payment of compensation shall secure and maintain full insurance against such employer's liability for payment of compensation under this article.

O.C.G.A. §34-9-126(a) states every employer subject to the compensation provisions of this chapter shall file with the Board in the form prescribed by the Board, annually or as often as the Board in its discretion may deem necessary, evidence satisfactory to the Board of its compliance with O.C.G.A. §34-9-121.

D. Penalties for Non-Compliance, Failure to Maintain Required Workers' Compensation Insurance Coverage

In addition to the penalty outlined in Section B above, O.C.G.A. §34-9-18(c) provides that the Board may assess a civil penalty of not less than $500 nor more than $5,000 per violation for the violation of O.C.G.A. §34-9-121 or §34-9-126(a).

Subsection (b) of O.C.G.A. §34-9-126 provides criminal sanctions for non-compliance by stating any employer subject to the compensation provisions of this chapter who refuses or willfully neglects to comply with Subsection (a) of §34-9-126 shall be guilty of a misdemeanor.

E. Penalties for Making False or Misleading Statements when Obtaining or Denying Benefits

O.C.G.A. §34-9-18(b) provides a civil penalty of not less than $1,000.00 nor more than $10, 000 per violation when any person knowingly and intentionally makes any false or misleading statement or misrepresentation for the purpose of obtaining or denying workers' compensation benefits or payments. O.C.G.A. §34-9-19 provides criminal sanctions against any person, firm, or corporation who willfully makes false or misleading statements or representations for obtaining or denying workers' compensation benefits or

payments. Upon conviction, a fine of not less than $1,000 or more than $10,000 or by imprisonment not to exceed 12 months or both may be levied.

F. Penalty for Employee's Fraudulent Receipt of Benefits

O.C.G.A §34-9-21 provides any employee who, with the intent to defraud, receives and retains any income benefits to which he or she is not entitled shall be guilty of a misdemeanor and upon conviction thereof, shall be punished for each offense by a fine of not less than $1,000 nor more than $10,000 or by imprisonment not to exceed one year or by both such fine and imprisonment.

G. Payment of Penalties

All civil penalties and cost assessed under these Code Sections shall be tendered to the State Board of Workers' Compensation.

Any person, firm or corporation assessed civil penalties according to these Code Sections may also be assessed the costs of investigation and/or collection. The cost of collection may also include reasonable attorney's fees.

Chapter 6

GEORGIA SUBSEQUENT INJURY TRUST FUND (O.C.G.A. §34-9-350 et seq.)

A. O.C.G.A. §34-9-350 et seq.

The Subsequent Injury Trust Fund, as part of Georgia's Workers' Compensation Law, is designed to reduce the impact of singularly large workers' compensation exposure in the event a worker with a disability, injured on the job, aggravates his/her earlier impairment. The fund works in several ways: (1) helps to keep employers' insurance premiums under control, (2) helps maintain an employer's insurability; and in the case of a self-insured employer, the self-insurer does not face workers' compensation exposure above the deductible levels.

As an employer, you must have knowledge of the previous permanent impairment and determine that it is likely a hindrance to employment. This knowledge must exist prior to the new injury for the resources of the Subsequent Injury Trust Fund to become involved. Prior knowledge of the conditions listed in O.C.G.A. §34-9-361 will satisfy this requirement. The employer's knowledge provision of O.C.G.A. §34-9-361 does not violate ADA laws.

Notification of a claim must be in writing, transmitted on the facsimile machine, or transmitted electronically and forwarded to:

The Georgia Subsequent Injury Trust Fund
Suite 500, North Tower
1720 Peachtree Street, NW
Atlanta, GA 30309-2420

Phone: (404) 206-6360
FAX: (404) 206-6363
TTD: (404) 206-0002
Website: www.ganet.org/sitf/

Chapter 7

REHABILITATION

A. Reference to Insurer/Self-Insurer Section.

See Insurer/Self-Insurer Section, Chapter 7, for rehabilitation information.

APPENDICES

STATE BOARD OF WORKERS' COMPENSATION

General Telephone List

EXECUTIVE DIRECTOR, Stan Carter.....404/656-2048

ATTORNEY FEES, Judge Meg Hartin 404/656-2930
CASE MANAGEMENT, Dana Prather 404/656-2017
CASE STATUS.....404/656-3818
ADR/CHANGE IN PHYSICIAN 404/656-2939
CLAIMS ASSISTANCE 404/656-3818
CLAIMS PROCESSING, Weymon Smallwood & Dana Prather.....404/656-2017
COVERAGE, David Shirley 404/656-3692
DATA PROCESSING SERVICES, Pam Carter 404/656-3815
DRUG-FREE WORKPLACE, Roslyn George 404/656-2048
ENFORCEMENT, D. Stan Bexley 404/657-1391
FORMS (TO ORDER), Mailroom 404/656-3870
FULL BOARD APPEALS, Lamar Samples.....404/656-9688
INSURANCE, Ron Simpson.....404/656-0861
LICENSURE/INSURANCE/SELF-INSURERS, Kathy Oliver 404/656-4893
LUMP SUM & ADVANCE PAYMENTS, Roslyn Ramsey 404/656-2929
MANAGED CARE & REHABILITATION, Deborah Krotenberg 404/656-3784
MEDICAL CLAIMS COORDINATOR, Tonya Wilson 404/463-0563
MEDIATION, Judge Elizabeth Lammers 404/656-2939
PERSONNEL, Sharon Jones 404/656-3697
PHYSICIANS, SURGEONS & PHARMACEUTICALS
FEE SCHEDULE, Roslyn George 404/656-2048
PROCEDURE MANUAL, Training Janet Long 404/656-5656
QUALITY ASSURANCE, Gloria Kitchens 404/651-9016
REHABILITATION CERTIFICATION REQUESTS, Regina Spencer.....404/656-3559
REHABILITATION FEE SCHEDULE, Deborah Krotenberg.....404/656-3784
REQUEST FOR FILE COPIES, Copy Unit 404/656-2924
SAFETY LIBRARY, Denise Fedrick 404/651-9057
STIPULATED SETTLEMENTS, Roslyn Ramsey 404/656-2929
SUBSEQUENT INJURY TRUST FUND, Anne Burnett 404/206-6355
SUPERIOR COURT APPEALS, Sheila Stubbs 404/656-2938
SWITCHBOARD & RECEPTIONIST.....404/656-3875
TTD RELAY SERVICE ONLY ..... 800/255-0135 (voice) 800/255-0059 (fax)
TOLL FREE NUMBER 1-800/533-0682
TRAINING, Procedure Manual Janet Long.....404/656-5656
WEBSITE ADDRESS .....www.ganet.org/sbwc

Faxes to the Board must be pre-authorized. Call the appropriate Board representative for their fax number.

APPENDIX E

SUMMARY OF WORKERS' COMPENSATION PROVISIONS

GEORGIA WORKERS' COMPENSATION ACT AMENDED ON:	7/1/94	7/1/96	7/1/97	7/1/99	7/1/00	7/1/01
TOTAL DISABILITY - CODE §114-404 - O.C.G.A. §34-9-261						
Waiting period	7 days	7 days	7 days	7 days	7 days	7 days
Waiting period recoverable after (consecutive from disability date)	21 days	21 days	21 days	21 days	21 days	21 days
Maximum weekly benefit	$275	$300	$325	$350	$375	$400
Percent of average weekly wage (13 weeks prior to accident)	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%
Minimum weekly benefit	$25	$25	$32.50	$35	$37.50	$40
Maximum weekly duration from date of disability and not date of accident	400**	400**	400**	400**	400**	400**
TEMPORARY PARTIAL DISABILITY CODE §114-405 - O.C.G.A. §34-9-262						
Maximum weekly benefit	$192.50	$192.50	$216.67	$233.33	$250	$268
Maximum weekly duration from date of injury	350	350	350	350	350	350
Percent of difference in wages before and after injury	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%
Total maximum compensation	$67,375	$67,375	$75,834.50	$81,665.50	$87,500	$93,800
PERMANENT PARTIAL DISABILITY - CODE §114-406 - O.C.G.A. §34-9-263						
Maximum weekly benefit	$275	$300	$325	$350	$375	$400
Percent of difference in wages	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%	66 2/3%

SPECIFIC MEMBER - LOSS OR LOSS OF USE OF:

	Weeks		Weeks
Thumb	60	Arm	225
1st (index) finger	40	Foot	135
2nd (middle) finger	35	Leg	225
3rd (ring) finger	30	Eye	150
4th (little) finger	25	Loss of Hearing (one ear)	
Great toe	30	Total Industrial	75
Other toes	20	Loss of Hearing (both ears)	
Hand	160	Total Industrial	150
Disfigurement	None	Disability/Whole Body	300

DEATH BENEFITS - CODE §114-413 - O.C.G.A. §34-9-265						
Maximum weekly benefit	$275	$300	$325	$350	$375	$400
Maximum duration from injury date	Various	Various	Various	Various	Various	Various
Burial expense	$5,000	$5,000	$5,000	$7,500	$7,500	$7,500
Total maximum benefit	$100,000*	$100,000*	$100,000*	$100,000*	$125,000*	$125,000*
	All others	All others	All others	All others	All others	All others
	Vary	Vary	Vary	Vary	Vary	Vary
PARTIAL DEPENDENTS						
According to the ratio that the contribution bears to wages, times the amount due a spouse - Maximum.	Various	Various	Various	Various	Various	Various
MEDICAL BENEFITS						
Medical Allowance	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
MISCELLANEOUS						
Interest in lump sum payment	7% per annum	7% per annum	7% per annum	7% per annum	7% per annum	7% per annum
Statute of limitations:						
For reporting accidents to the Board (see OCGA §34-9-82)	1 or 2 yrs	1 or 2 yrs	1 or 2 yrs	1 or 2 yrs	1 or 2 yrs	1 or 2 yrs
For appeal to Three Member Board (from date of prior award)	20 days	20 days	20 days	20 days	20 days	20 days
For appeal to Superior Court (from date of prior award)	20 days	20 days	20 days	20 days	20 days	20 days
For appeal to Court of Appeals (from date of prior award)	30 days	30 days	30 days	30 days	30 days	30 days
Number of employees required to come under law	3	3	3	3	3	3

***Surviving spouse only after one year

****Except for catastrophic injures which are unlimited

GEORGIA STATE BOARD of WORKERS' COMPENSATION FORMS – JULY 2002

Board forms are available as hard copy cut forms from the State Board of Workers' Compensation. To order call 404-656-3870. Forms may also be downloaded from the Board's web site www.ganet.org/sbwc (requires Adobe Acrobat 4.0©)

Form #	Revision Date	Color	Title
WC-1	2002	White	Employer's First Report of Injury
WC-2	2001	White	Notice of Payment or Suspension of Benefits
WC-2a	2001	White	Notice of Payment or Suspension of Death Benefits
WC-3	2001	White	Notice to Controvert
WC-4	98	White	Case Progress Report
WC-6	2000	White	Wage Statement
WC-7		White	Application for Self-Insurance* (Packet available through Licensure & Quality Assurance Division (404) 656-4893)
WC-10	99	White	Notice of Election or Rejection of Workers' Compensation Coverage
WC-11	98	White	Standard Coverage Form Group Self-Insurance Fund Members
WC-12	98	White	Request for Copy of Board Records
WC-14	2001	White	Notice of Claim/Request for Hearing/Request for Mediation
WC-15	2002	White	Attorney Affidavit for No-Liability Stipulations
WC-20(a)	99	White	Medical Report
WC-24	2001	White	Fraud And Compliance Request For Hearing or Trial Division Intervention
WC-25	2000	White	Application for Lump Sum/Advance Payment
WC-26	2000	White	Consolidated Yearly Report of Medical Only Cases
WC-100	2002	White	Request for Settlement Mediation
WC-102	2001	White	Request for Documents to Parties
WC-102B	2002	White	Notice of Representation
WC-102C	2002	White	Attorney Leave of Absence
WC-102D	2002	White	Motion/Objection to Motion
WC-104	98	White	Notice to Employee of Medical Release to Return to Work with Restrictions or Limitations
WC-108a	2001	White	Attorney Fee Approval
WC-108b	2001	White	Attorney Withdrawal/Lien
WC-121	98	White	Notice of Use of Servicing Agent
WC-200a	99	White	Change of Physician/Additional Treatment by Consent
WC-200b	98	White	Request/Objection for Change of Physician/Additional Treatment
WC-205	2001	White	Request for Authorization of Treatment or Testing by Authorized Medical Provider
WC-206	98	White	Notice of Intent to Become a Party at Interest
WC-207	98	White	Authorization and Consent to Release Information
WC-208a		White	Application for Certification of WC/MCO* (Packet available through Managed Care & Catastrophic Disability Division (404) 656-3784)
WC-226(a)	2001	White	Petition for Appointment of Temporary Guardianship of Minor
WC-226(b)	2001	White	Petition for Appointment of Temporary Guardianship of Legally Incapacitated Adult
WC-240	2002	White	Notice to Employee of Offer of Suitable Employment
WC-240A	2002	White	Job Analysis
WC-243	98	White	Credit/Reduction in Benefits
WC-244	98	White	Notice of Intent to Become a Party of Interest
WC-BOR	2002	Pink	Bill of Rights **(MUST BE POSTED IN PINK)**
WC-BOR-SP	2002	Pink	Bill of Rights – Spanish **(MUST BE POSTED IN PINK)**
WC-P1	2002	Pink	Panel of Physicians **(MUST BE POSTED IN PINK)**
WC-P1Sp	2002	Pink	Panel of Physicians in Spanish **(MUST BE POSTED IN PINK)**
WC-P2	2001	Pink	Conformed Panel of Physicians **(MUST BE POSTED IN PINK)**
WC-P2Sp	2001	Pink	Conformed Panel of Physicians in Spanish **(MUST BE POSTED IN PINK)**
WC-P3	2001	Pink	WC/MCO Panel **(MUST BE POSTED IN PINK)**
WC-P3Sp	2001	Pink	WC/MCO Panel in Spanish **(MUST BE POSTED IN PINK)**
WC-R1	2002	White	Request for Rehabilitation
WC-R1CATEE	2002	White	Request for Catastrophic Designation
WC-R2	2002	White	Rehabilitation Transmittal Form
WC-R2a	2002	White	Individualized Rehabilitation Plan
WC-R3	2002	White	Request for Rehabilitation Closure
SUBPOENA	2002	White	Subpoena

APPENDIX F